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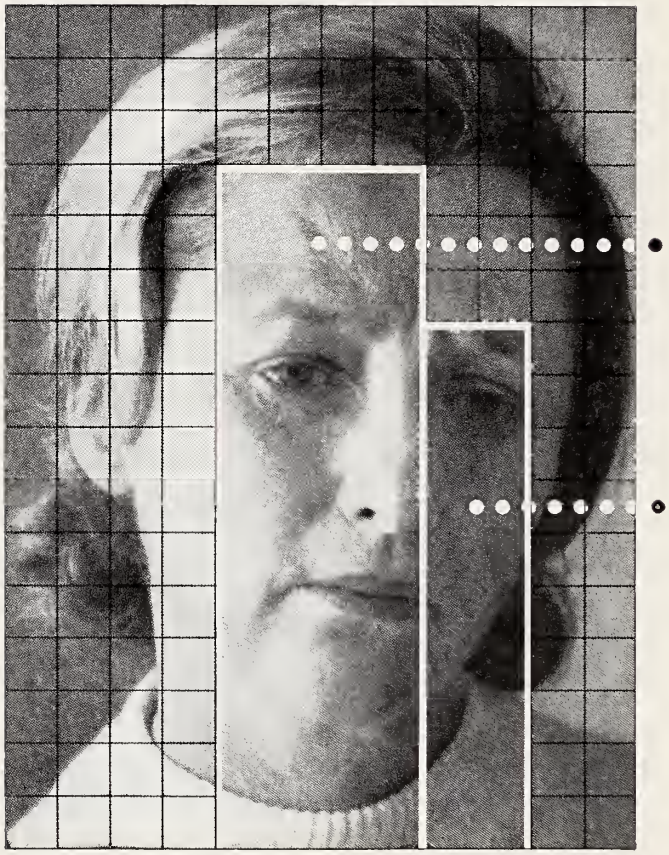
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The Ovid Bell Press, Inc.
1201-05 Bluff Street
Fulton, Missouri 65251

Second Class postage paid at Fulton, Missouri.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

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Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

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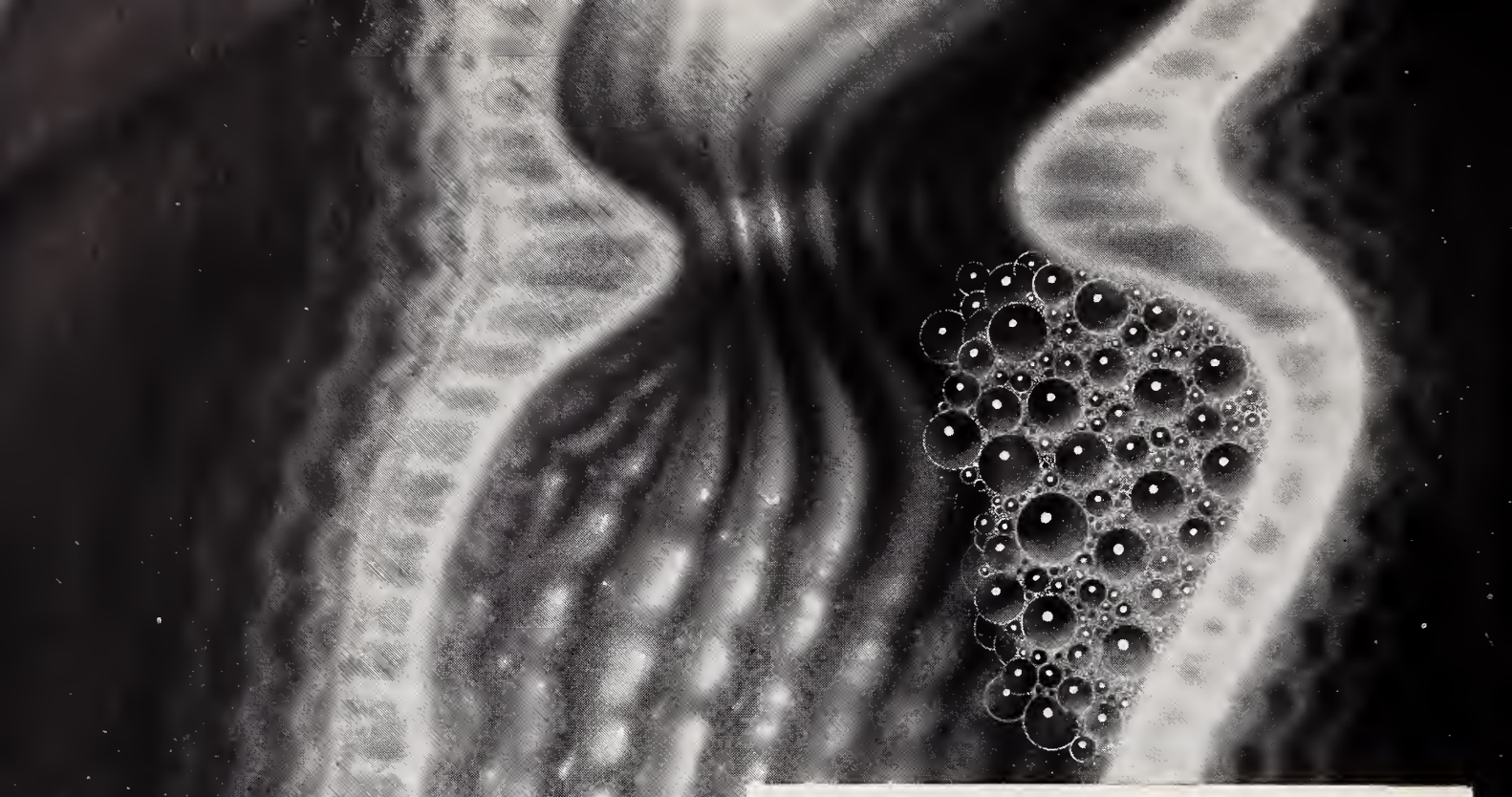
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THE COVER

We hope to put together the "puzzle" of health maintenance organizations with several articles in this January issue. Cover design by Atlanta artist Bob Hamill.

324134



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Report of the Ad Hoc Committee to Study HMOs

CHARLES R. UNDERWOOD, M.D., CHAIRMAN, *Marietta**

THE HEALTH MAINTENANCE ORGANIZATION Act of 1973, Public Law 93-222, was signed into law by President Nixon January 1, 1974. It was then in anticipation of the far-reaching implications of this law that the MAG Executive Committee on January 12, 1974 appointed the Ad Hoc Committee to study the newly-enacted federal HMO statute. The Committee consists of Charles R. Underwood, chairman, Carson Burgstiner, Luther Thomas, F. G. Eldridge, David Wells and Mr. Winston Huff, legal counsel.

Mindful of MAG's basic principles on the delivery of health care, this committee has worked toward developing a proposed Georgia law governing HMOs.

Basic Principles

During this past year, the Committee has met several times and carried out an in depth investigation of the federal law. The basis of our initial study was a reassessment of some 13 principles compiled by the Committee on Private Practice in September 1972. These principles were an attempt to summarize the basic position of the Medical Association of Georgia relating to the entire question of health maintenance organizations. These principles include the feeling that the direct delivery of medical services should be limited to licensed physicians and dentists, the governing body of any HMO should be controlled by physicians, premiums should be arrived at by experience rating, a separate department of state government should be organized to control the law, advertising should be prohibited, a grievance mechanism should be provided, the open panel variety of HMO should be encouraged as opposed to the closed panel and a few other such basic position statements. It was recognized early in our study that many of these "principles" were in direct conflict with the federal law.

The Committee first reported to the Executive Committee March 9, 1974 recommending that we continue our opposition to the development of HMOs in the state and reaffirming the belief in the validity of the original "13 principles." We recommended that the 13 principles be rewritten and restudied further and finally that no MAG-sponsored HMO law be formalized at that time.

The Committee next reported to the Council in May 1974, at which time a revision of the original 13 principles was presented. We recognized at this time that an HMO law had been introduced in the Georgia General Assembly in 1971 and 1972, although a law had not been introduced in 1973. After considerable discussion, the Committee was directed by Council to proceed with the formal preparation of an HMO law which could then be studied by Council and the House of Delegates, but which would not necessarily be introduced in the legislature. Winston Huff, legal counsel to the MAG, was asked to proceed with the preparation of such a law.

At the September 12, 1974 meeting of Council a draft in outline form of an HMO law for the state of Georgia was studied by the Committee. After considerable discussion concerning a number of points in the law, the draft was presented to Council at this time.

At the November 1974 meeting of Council in Atlanta, the draft of the HMO law was further refined and once again presented to Council. It is the hope of the Committee that this law can be completed and ready for final evaluation by January 1975.

Maintaining Care Level

This legislation, as it is presently evolving, at-

* Dr. Underwood's practice in surgery is at 641 Church St., Marietta, Ga. 30060. He also serves the association as vice councilor from Cobb County and member of the committees on cancer and insurance and economics.

tempts to define the mechanism whereby any interested group might organize and set into operation an HMO in Georgia. It furthermore will embody principles which are felt to be important to the continuation of and improvement of the present high level of medical care in the state, taking full cognizance of cost containment and access to the health care system. There are certain aspects of the federal law which are repugnant to us, for example, closed panels and advertising provisions and rating structure, to such a degree that we have not incorporated these matters in the present law. Although certainly no conscious attempt to write a state law which would be in direct conflict with the federal law has been made, nonetheless as our present law evolves it is clearly apparent that it will not satisfy all of the requirements of a federally-approved HMO under Public Law 93-222. It would, in other words, be possible for an HMO to be organized under the state law and yet not qualify for federal funding under the federal statute.

In summary, therefore, it is the feeling of the Ad Hoc Committee charged to study health maintenance organizations in Georgia that the establishment of such organizations is no longer a matter for debate but rather an existing fact which must be accepted as such. An HMO sponsored by the Medical Association of Atlanta is now in operation in Atlanta. (See a report by Dr. Charles Todd elsewhere in this *Journal.*) A great deal of discussion is now going on concerning the development of other HMOs throughout the state. Although a final decision to introduce enabling legislation has not been made, it is the present prevailing sentiment that it would be wise to have fully prepared and approved an HMO law which could be introduced in the Georgia legislature at such time as the MAG might feel this action would be wise. We would hope to write this law along lines and containing principles thought to be important and necessary to the continuation of quality health care for the people of Georgia. ■

Atlanta Graduate Medical Assembly Examines Infectious Disease

Infectious disease will be the main subject explored at the 1975 Atlanta Graduate Medical Assembly scheduled for March 10-12 at the Fairmont Colony Square Hotel in Atlanta. The final day's program is devoted to this topic and lectures are planned suited to all specialties involved.

The faculty on infectious disease includes Robert Petersdorf, chairman of the Department of Medicine of the University of Washington in Seattle and president of the American College of Physicians. He will be joined by Edward Hook of the University of Virginia, Jay P. Sanford of University of Texas Southwestern Medical School and Louis Weinstein of Tufts University.

The first day of the Assembly Monday, March 10, will be devoted to cardiology with George Burch, Tulane; Dr. Weinstein; and Peter M. Yurchak and Jan Koch-Wesser from Harvard Medical School. Monday's section on surgery and Tuesday's on cancer share same faculty. Rupert Turnbull of the Department of Colon and Rectal Surgery, Cleveland Clinic is featured.

The program Tuesday also will include lectures in the area of infertility with C. Alvin Paulsen of the University of Washington and Paul G. McDonough of the Medical College of Georgia; and a program on adolescent medicine with Robert Blizzard of the University of Virginia, John Phillip Tindall of Duke University and Robert P. Masland, Jr., from the Children's Hospital Medical Center in Boston.

Specialty societies joining the Medical Association of Atlanta in planning and sponsoring the Assembly are the American College of Physicians, the Georgia Society of Internal Medicine, Georgia Heart Association, Georgia Chapter of the American College of Surgeons, Georgia Division of the American Cancer Society, Atlanta Obstetrical and Gynecological Society, Georgia Academy of Family Physicians and the Greater Atlanta Pediatric Society.

Making up the Executive Committee for the 1975 program are Carter Smith, Jr., general chairman; Judson L. Hawk, Jr., faculty and curriculum chairman; Alton V. Hallum, Jr., exhibits chairman, William C. Waters, III, exhibits co-chairman and John P. Wilson, hospitality chairman. Wynell S. Hopkins serves as executive secretary.

The program will be accepted for Category I credit of the AMA Physicians' Recognition Award and for prescribed credit with the American Academy of Family Physicians.

Social events for the Emory Medical Alumni and the Atlanta Obstetrical and Gynecological Society are being held in conjunction with the meeting and tickets will be available at the registration desk. Tours of historic homes and a Tuesday luncheon have been planned for wives of physicians attending the Assembly.

Additional information and registration forms are available from the Medical Association of Atlanta, 875 West Peachtree St., N.E., Atlanta, Ga. 30309.

A model act, acceptable to most private practice physicians, which would be used if other unacceptable legislation were proposed, is described below.

A Proposed HMO Law for Georgia

J. WINSTON HUFF, *Atlanta**

HEALTH MAINTENANCE ORGANIZATIONS (HMOs) are increasingly a topic of conversation in medicine these days. An HMO can take many forms, but is generally defined as a direct-service plan responsible for delivering health care on a contractual prepaid capitation basis.

The movement toward HMOs was given impetus by federal funding authorized late in 1972. The federal legislation does not create HMOs, but does authorize federal planning grants and loans provided the HMO meets federal standards.

Georgia now has no law specifically governing HMOs. However, it is quite possible that an HMO law may soon be introduced in the Georgia General Assembly. Therefore MAG Executive Committee appointed an *ad hoc* committee chaired by Charles Underwood, M.D., to draft a model act which would be generally acceptable to the private physicians of this state if some other group introduces unsatisfactory legislation. The Committee has not yet completed its drafting, but an outline of the provisions of this proposed law has been approved by the Executive Committee of the Council. The principal points of this proposed statute are set forth below.

Description of an HMO

An HMO would be a non-profit corporation organized under the Georgia laws governing non-profit corporations. It must be operated as provided in the proposed law, and would also have to offer basic health services for a fixed, prepaid amount without regard to frequency or extent of services to a particular subscriber.

The basic health services which an HMO must offer would be those services reasonably required to maintain a person in good health, including, as a minimum, emergency care, inpatient hospital and physician care, outpatient health services, and preventive health services. These services could only be provided by the following: a licensed doctor of medicine, doctor of osteopathy, or a licensed dentist; a licensed hospital or other health care facility; or another provider of health services on order of or under the direction of a licensed physician or dentist.

For new HMOs the incorporators would have to be licensed MDs or DOs. Existing non-profit corporations which meet the requirements of the law could also qualify. A majority of the Board of Directors of an HMO would have to be MDs or DOs.

No HMO-type services could be offered to the public except upon compliance with the HMO law.

Certificate of Authority and Regulation

HMOs basically would be regulated by the Department of Human Resources of the state of Georgia. Before an HMO could begin operation, it would have to apply to the DHR for a certificate of authority. The application would include certain documents such as articles of incorporation, bylaws and the like, information as to officers and directors, a description of the geographic area to be covered, a description of the plan or plans to be offered, facilities, personnel, financial statements, method of marketing, and a schedule of charges.

An HMO would have to demonstrate to the DHR its ability and financial responsibility to assure that the basic health services would be provided and that its obligations would be met. The HMO would have to have an adequate peer review system and a means of providing quality assurance. It would have to make provisions for collecting adequate data as to use, cost and financial soundness. Its premium

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer and Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

schedule would have to be reasonably related to the services provided. An annual report would have to be provided to the DHR showing financial matters, number of subscribers, and services rendered during the year.

The DHR would be empowered to require an HMO to suspend or cease its activities upon a finding that it had departed from its basic organizational documents, had not fulfilled its obligations to its subscribers, or had not complied with the provisions of law. If the DHR finds an HMO to be in a failing condition, it may ask the Insurance Commissioner of the state of Georgia to step in and to oversee the rehabilitation, liquidation, or conservation of the HMO as in the case of an insurance company.

Powers and Prohibitions

An HMO will have the powers generally accorded to other corporations such as to contract, to own, buy and sell property, and the like. It will have the additional power to sell contracts to provide basic health services to its subscribers. These services could be provided by the HMO through its own financing or the HMO can insure its services by contracts with insurance companies. It will have the power to contract with providers for health services and with other persons for administration, marketing, data processing, actuarial analysis, and billing. It will be empowered to furnish its providers with fringe benefits such as continuing education, group life and health insurance, and malpractice insurance.

The law would prohibit untrue, misleading or deceptive advertising and solicitation. Health contracts would be cancellable only for failure to pay a premium, termination of the plan, or movement of the subscriber outside of the geographical area of the HMO. It would not have the power to terminate a contract for reasons of age, sex, or health status.

Advertising would be permitted only to indicate the existence of the HMO and the scope and cost of services. No advertisement can identify the physicians involved nor tout the skill and ability of these physicians. There would be no cash payments or dividends to subscribers. HMO income cannot be used for any purpose except to pay for the services delivered.

Types of Plans

Each subscriber would be issued a written contract specifically describing the services and care afforded. All plans must be experience rated and not community rated. The law would prohibit a "closed panel" plan. That is to say, any licensed physician in the geographical area of an HMO who met the qualifications required could become a provider, and patients would be free to choose any physician who became a participant in the plan. This would differ from the so-called "closed panel" plan where a limited group of physicians or a particular clinic provides all of the physicians' services, and the patient must go to those physicians for treatment.

Complaints

The law would require that an HMO set up a grievance system for the airing of complaints by both subscribers to the plan and physicians and other persons who provide services to those subscribers.

Confidentiality

Although financial statements and reports would be required to be sent to the DHR and perhaps to the Insurance Commissioner, patient records would be confidential except under lawful subpoena. Further, the amount of fees paid to any particular health provider or to any group of health providers would be confidential information for the use of the Insurance Commissioner and the Department of Human Resources only.

Reinsurance

As mentioned above, insurance companies and non-profit service corporations (Blues) will be empowered to contract with HMOs to provide insurance against the cost of care and coverage. This could be done in whole or in part. The hospital care might be insured, while the responsibility for the payment of physicians participating in the plan would be that of the HMO itself. Many variations of payment are possible, and the power to insure one or more risks will give the HMO flexibility. Hospitals will be empowered to contract directly with an HMO for hospital care.

Offering to Public Employees

The employees of the state of Georgia and any political subdivision of the state may become subscribers in any HMO. If there is an HMO in a particular geographical area, any political subdivision within that area must offer HMO coverage as an option to any other health insurance coverage then being offered. Payroll deductions for payments to the plan would be permitted.

As indicated elsewhere in this issue of the *Journal,* it has not been MAG policy to encourage establishment of HMOs. Therefore the law described above will not be introduced unless HMO legislation arrives on the scene. At that time it will be available as a substitute bill in the event that other legislation does not meet MAG criteria. ■

Conversation With the Medical Director of a Denver HMO

JMAG: Dr. Reimers, tell us a little about your background in the medical profession and how you came to be the medical director of a health maintenance organization.

REIMERS: In 1969, when the Colorado Permanente Medical Group was formed as part of the Kaiser-Permanente Program of Colorado, I had been a private, fee-for-service, boarded general surgeon in Denver for 17 years. As one of the three founding members of the medical group, my main interest was to build a surgical department in a growing prepaid group. I became so involved in problems relating to our survival that a year later I accepted the position of medical director. As for my reason for changing from solo, fee-for-service to a salaried position in a prepaid group: I convinced myself that moderately priced, high quality, comprehensive medical care could be delivered only if the physician(s) had substantial control over the quality and quantity of all services rendered to the patient.

JMAG: Please explain the organizational setup of your particular HMO. What is the ownership? What facilities do you have and what hours do you operate? What are your hospital services, professional services, management services, etc.?

REIMERS: The Colorado Permanente Medical Group is a professional corporation that has a contractual relationship with the Kaiser Foundation Health Plan of Colorado to provide or arrange for professional services to Health Plan members. The Kaiser-Permanente Health Care Program of Colorado is a jointly managed operation integrating the professional (CPMG) and the administrative functions (KFHP) necessary for total health care to members. Though we have three outpatient facilities accommodating 54 physicians, only one of these clinics is wholly owned by us. We provide 24-hour, 7-day a week service, though after clinic hours and on weekends patients are seen in the outpatient department of our principal hospital. Community beds are used for hospitalization of our members, concentrating them as much as possible to two mid-town Denver hospitals.

JMAG: What reaction did you find to your group in the medical community? How did fellow physicians feel about the creation of this HMO in the beginning and has the attitude changed since then? Do any of the physicians consider you a threat?

REIMERS: The Denver medical community is an unusually progressive and fair-minded one. Though we were not initially accepted with a warm embrace, there was little open or organized hostility toward us. Organized medicine took a very statesman-like view—the quality of our medical care would receive the same scrutiny as that of all other delivery systems. The founding physicians, as well as our new ones, remained or became members of the local medical society, and of hospital committees. Though



AS A FORMER PRIVATE practice surgeon, now involved with a prepaid plan as its medical director, we asked W. L. Reimers, M.D. of Denver, Colorado to respond to a series of questions for our *Journal* on his experiences with this new mode of health care delivery.

Dr. Reimers was graduated from the University of Nebraska College of Medicine in 1943, then served his internship and residency at Ohio State University and the University of Colorado, with a two-year interruption for service in the U. S. Army during World War II.

He entered private practice in Denver in 1953 and soon after began serving as an assistant clinical professor in surgery at the University of Colorado. He is also currently a lecturer in the field of medical care delivery for the University's Department of Preventive Medicine.

Active in association work, Dr. Reimers is the original chairman and continuing member of the Council on Socio-Economics of the Colorado Medical Society, chairman of the Relative Value Study Committee and member of the Foundation Study Team. He served as a member of the Colorado Blue Shield Board of Trustees in 1969. He is a Diplomate of the American College of Surgeons and past president of the Denver Academy of Surgery.

we may be considered a threat by some, generally our relationship with fee-for-service physicians is one of mutual respect.

JMAG: Please describe the staff for us—how were the members recruited, what percentage come from which specialties? What are the ages and backgrounds of most staff members? Have most stayed with you?

REIMERS: Our internal staff of 54 physcians represents the specialties of internal medicine, surgery, ob-gyn, pediatrics, ENT, ophthalmology, psychiatry, orthopedics and radiology. All of our physicians are board-eligible and 75 per cent are certified. All primary care is delivered by the specialties mentioned. We do not currently have a family practice service, though one is considered. Recruits are generally physicians who have just finished their residency training and, consequently, are usually in their early 30s. Turnover of physicians has been about five per cent per year.

JMAG: What working arrangement does the Group have with staff members? Are most full or part time? What benefits are received in addition to salary? Can the physicians choose the patients they will accept? What personal liability does each have for the failure of the HMO?

REIMERS: Though we used a number of part time physicians in our early years, almost all of our staff are now full time, career physicians. Benefits include a retirement program, malpractice insurance, life and disability insurance, Health Plan coverage, medical society dues, education time and travel allowance. The cost of these benefits is about 25 per cent of salary.

The physician staff realize that collectively the group has an obligation to provide care to a defined population. The members are encouraged to select a primary physician from the staff and to seek all future appointments with him. Physician acceptance of this generally has been good. New members are encouraged to see our newer doctors in order to equalize the clinical load.

After three years of service, an employed physician is eligible to become a partner. As such he shares equally the financial rewards (good or bad) with all other partners.

JMAG: How many members, or patients, does the group cover and how do these people join? Have you found that over-utilization is a problem? What is the usual time lag in getting appointments and how are emergencies handled?

REIMERS: The K-P Health Plan of Colorado now covers nearly 60,000 members. Though individual membership is possible, most join through a multiple-choice option with employment groups. With the group enrollees, we are obligated to accept all comers.

Over-utilization has not been a problem, except possibly with routine eye refractions. I must emphasize that HMOs must be very sensitive to the opposite problem: under-utilization.

Appointment waiting times vary from hours to months, depending upon the urgency of the service. Emergencies are handled departmentally during clinic hours, and through the hospital emergency room during off hours.

JMAG: What is your relationship with Medicare and Medicaid?

REIMERS: We have a formal Health Plan/Medicare integrated medical and hospital benefits program which is available to individuals who have both Parts A and B of Medicare.

Our organization in Colorado has no involvement with an established Medicaid program, though there are a few individual Medicaid beneficiaries who are members of our plan.

JMAG: How do you view PSRO and NHI and how they will relate to the future of the medical profession and HMOs?

REIMERS: With much concern! In the long run, I think we can work very compatibly with our local PSRO—if it remains a physician function. As for NHI, who knows? Certainly existing and proposed legislation will greatly change the practice of medicine for us all. ■

REVISED ABORTION CERTIFICATES AVAILABLE

Any physician concerned with cases of spontaneous or performing an induced abortion is required to file a certificate with the Department of Human Resources within 10 days of the abortion. Certificates of spontaneous abortion should be filed with the county registrar.

New fetal death certificates, revised to obtain more needed information, went into effect January 1, 1975 and may be obtained from Vital Records, 47 Trinity Avenue, Atlanta, Ga. 30334. A manual explaining how to fill out the certificates also is available. Old certificates should be discarded.

If information on Georgia's abortion laws is needed, contact Vital Records at (404) 656-4900.

Open panel type HMOs are favored over closed panel ones in this report of a two year study into this form of health care delivery.

Metropolitan Atlanta Foundation's Concept for Prepaid Health Care Plans

CHARLES E. TODD, JR., M.D., *Atlanta**

The Metropolitan Atlanta Foundation for Medical Care first became interested in HMOs in 1972 when President Nixon stated that HMOs would be the mechanism for delivery of health care in the United States in the future, and predicted that by 1980 a substantial portion of patients in this country would be under such a plan. Since we knew very little about HMOs it was felt that we should attempt to study the problem and try to devise an HMO that would retain as many of the good aspects of the private practice of medicine as possible.

As a result of this decision, we applied for and received planning grants covering two years from the Department of HEW to be used for this purpose. We have learned a lot from this study and I am pleased to have this opportunity to pass this information on to the members of the Medical Association of Georgia.

The term "HMO" is a very difficult thing to define and means many different things to different individuals and includes many divergent concepts. An HMO has been defined as a legal entity which provides comprehensive health services (basic and supplemental) to its member patients for a predetermined sum, prepaid on an intermittent basis. I suppose that this definition is a good starting point but it really doesn't cover the important issues of who, when, where, how and how much. It does imply an element of risk on the part of physicians but this risk is small (perhaps 10 to 15 percent of his fees involved in such a program). When one accepts risk he expects the possibility of gain for having done so and this is built into most HMO plans. In actuality under our private practice system we accept some risk each time we accept a new patient for care. We certainly do not receive payment for all care rendered our patients. As far as the prepayment portion is concerned, a considerable portion of our fees is now being prepaid by our patients in the form of insurance and this is particularly true for those of us who are involved in surgery and obstetrics and gynecology. Recently this is becoming increasingly true for physicians in the other specialties.

* Dr. Todd is president of the Metropolitan Atlanta Foundation for Medical Care, Inc., and was president of the Medical Association of Atlanta in 1972. His practice in surgery is located at 35 Collier Road, N.W., Atlanta, Ga. 30309.

Defining Open and Closed

Perhaps the most important thing discovered on this study is the drastic difference between the two principal types of HMOs (open panel and closed panel). There are variations within each of these two types, but the following information will serve to delineate the differences between the two. In talking, reading and thinking about HMOs, it is essential that you first determine which of these programs is involved.

The closed panel HMO is usually formed by a small group of physicians and participation by other physicians is prohibited except by invitation and involvement in this type of group practice. Most physicians in closed panel HMOs are on a salary and at the end of the year, if the experience has been good, the group will determine how much of the remaining funds each physician will receive as a bonus. This type of plan also usually involves the delivery of care from a single structure or clinic. Patients who are enrolled in closed panel HMOs have to see the physicians who are members of this closed panel. They may be referred, at the discretion of the physicians, to doctors outside of the closed panel, but actually patients do not enjoy freedom of choice of physicians. Also, the physicians must treat those patients who are members and thus have little freedom of choice in determining whether they will accept a particular patient or not.

Possible Unethical Competition

We are opposed to closed panel HMOs for those reasons listed above and also because it involves an unhealthy and almost unethical competition between

groups of physicians. Imagine in your community there being two or more closed panel HMOs who are competing with each other on the open market with individuals, labor, and management for contracts to deliver health care to the industries in your area. This theoretically could lead to one group bidding against the other with the contract going to the lowest bidder. This type of activity is totally foreign to us as a profession. It could only lead to a decrease in the quality of care rendered because of the necessity of reducing costs in order to live within the money limitations of the contracts. It could force non-HMO members to move or to form other closed panel HMOs for the preservation of their practice. I admit that this is an unlikely situation but it serves the purpose to support my opposition to closed panel HMOs.

On the other hand, an open panel HMO would be open to all members of the profession who are licensed to practice medicine in that state. It would maintain a fee for service system of payments on a usual, customary and reasonable basis. Outpatient delivery of health care would be rendered in physician's offices and existing outpatient facilities, while inpatient services would be rendered in existing hospital facilities in the area. Since this plan envisions the involvement of the majority of physicians in an area, there would be freedom of choice of physicians on the part of the patients and total freedom of choice of patients as far as physicians are concerned.

We feel quite comfortable in supporting this type of HMO. First of all, it is open to any physician who is interested in becoming part of the program and would involve only a portion of his practice. It would maintain the normal doctor-patient relationship and would not alter a physician's normal referral practices. It would now give physicians control of the health care dollar and who knows better than the physician how and where this dollar should be spent. Physicians would be in complete control of the program. I feel that such a program would give our patients the most for their health care dollar. The health dollar could be spent in a manner in which medical services are rendered rather than by some preconceived idea of health planners or insurance companies. This always reminds me of the insurance policy which advertises that it will pay for blood transfusions but in fine print states that it will pay for all blood transfusions after the first six.

Budgeting Medical Costs

Another important factor is that it would allow our patients to budget their medical costs. A member of this type plan would know the limitations of the payment which he would be required to make above the cost of the program for co-payments. He would be assured that this would be the maximum limits of his health care cost for him and his family for that year. In this day of impending national health insurance this factor becomes extremely important. Since the program would be subject to peer review and concurrent hospital review, it is felt that the quality of care would improve. Peer review in the past has done a reasonably good job with inpatients, but under this program peer review would also be involved in outpatient care. Peer review under this circumstance would not be done for punitive purposes but would be done to identify educational needs and would include an educational program. This plan would also be an answer to any closed panel HMOs in the area.

There are other advantages to having this type of program. In the present period of recession and inflation, it would not seem unlikely that the Cost of Living Council would once again be reinstituted and if its policies are similar to those of the past, prepaid medical plans of this sort would be exempt from their regulations. This type of program also lends itself quite well to the deferred payment type of retirement programs which would offer many advantages to a physician which are not available in corporate practice retirement plans and the Keogh Plan. We don't know how the national health insurance programs will operate and it is conceivable that an open panel HMO could possible be the last vestige of the private practice of medicine.

Potential HMO Devised

The Metropolitan Atlanta Foundation for Medical Care has devised a potential HMO for our area. It involves a comprehensive health package devised according to the way medicine is practiced and covers inpatient and outpatient care. If instituted it would be marketed to groups and would include peer review, concurrent review, discharge planning, and a patient education program. Simple claim forms would be devised and physicians could enjoy prompt payment of claims. Re-insurance would play a part in the program on both individual members and total program in order to limit the risk taken by physicians.

At present, Georgia laws prevent us from establishing an HMO in our area. The recently passed Federal HMO law does preempt some state laws but not enough to allow the development of HMOs in this state. This law has many objectionable components and in essence would put the HMO under the control of the Secretary of HEW. It is also slanted to enhance the formation of closed panel

HMOs and many aspects of this law are detrimental to medicine. It would also be extremely difficult to market the comprehensive package which is required under this law in this area. The cost would be prohibitive.

We could begin an HMO in conjunction with an insurance company and we are at present negotiating with Blue Cross/Blue Shield to see if this approach is practical. Under the present federal and state laws an insurance company could begin an HMO and if we decided to become an insurance company it would be possible for us to do so. This too is financially unfeasible.

Favorable North Fulton Experience

We have had the opportunity to establish an HMO-like program in the northern part of Fulton County. We have a contract with the Fulton County Commissioners for the delivery of inpatient and outpatient care to a group of indigent, Grady eligible patients located in the northern three census tracts of Fulton County. This program has been in effect for approximately one and one-half years and has been most favorably accepted by the involved patients and some 400 physicians who work in that part of the county. Our experience with this program has been very gratifying and certainly has established the fact that an open panel HMO can work when it is managed by the physicians involved.

In summary, we feel that medicine can support open panel type HMOs as outlined above. We are certainly opposed to closed panel HMOs. We recognize that there are some advantages in experimenting with this relatively new approach to the financing and management of a health care program. It is hoped that this article will have clarified some of the problems involved in HMOs and that you will have a better concept of what is involved and can better evaluate future articles and discussions on this subject. ■

A PRACTITIONER'S GUIDE TO DIAGNOSTIC X-RAY EQUIPMENT STANDARDS

A reference booklet on the federal diagnostic x-ray equipment standard is now available from the Food and Drug Administration's Bureau of Radiological Health and summarizes what practitioners need to know to meet their responsibilities as stipulated by the standard. These responsibilities primarily involve equipment maintenance and assembly of x-ray systems and components. The publication discusses at length the requirement that x-ray equipment owners who install their own components are subject to provisions of the standard.

The standard became effective August 1, 1974 and was issued by the FDA under authority of the Radiation Control for Health and Safety Act to reduce unnecessary patient exposure during diagnostic x-ray examinations. Its significance lies in the fact that 90 per cent of the U.S. population's exposure from manmade radiation sources is attributed to the diagnostic use of x ray.

Single free copies of "A Practitioner's Guide to the Diagnostic X-Ray Equipment Standard" are available from the Bureau of Radiological Health (HFX-25), 5600 Fishers Lane, Rockville, Maryland 20852. Multiple copies, quoting stock number 1715-00075, should be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. The price is 40 cents per copy, with a 25 per cent discount for orders of 100 or more.

NEW EMORY BRAIN X-RAY SYSTEM USES COMPUTER TO FORM IMAGE

Emory University Clinic has completed installation of a radically new x-ray system for the investigation and diagnosis of brain diseases. The system, manufactured in England performs the computerized transverse axial tomography or CTAT and this new model provides much more information than other similar devices in use throughout the country.

Emory neuroradiologist James C. Hoffman, M.D. says this type of examination offers several advantages over the currently available procedures in that it does not require the injection of radioactive materials or contrast-producing agents and does not bring discomfort or risk to the patient.

The CTAT system, which allows the radiologist to visually observe tumors, cysts and hemorrhages utilizes a digital computer to form the picture, according to Dr. Perry Sprawls, a radiological physicist on the faculty of the Emory University School of Medicine.

The instrument passes a small pencil-like beam through the patient's head and radiation detectors placed in the beam determine the amount of penetration. The beam scans, taking 240 readings of x-ray transmission. This is repeated at 180 different angles resulting in 43,000 measurements of x-ray transmission. This information is used by the computer to produce a picture of a selected slice or plane through the skull, and brain abnormalities can be located and diagnosed.

A careful explanation of the problem and steps physicians and their associations can take to alleviate it are given.

The Malpractice and the Insurance Carrier

WAVERLY G. SMITH, *St. Paul, Minnesota**

My COMPANY and I are deeply honored to have this opportunity to talk about an ugly subject. We are encouraged by your decision to include the matter of medical malpractice on your busy meeting program; a major challenge in dealing with the malpractice crisis is the reluctance of many fine physicians and surgeons to consider the situation as a problem they personally can do something about.

Malpractice *is* an ugly word. A single malpractice claim can tie up a good deal of your time for years and cause damaging publicity. An allegation of malpractice strikes at the heart and soul of your professional oath. The charge that you have given less than the best you can provide to a patient is a shattering charge. You feel betrayed. You resent the plaintiff's attorney earning money by doing his best to prove you did poorly.

Malpractice is an ugly word to us too. The sharp increase in the number of malpractice claims and jury awards, plus inflation, has increased claims payments, sharply hiked legal defense costs and made this business a major money loser. The malpractice crisis is on the brink of becoming a disaster, for us and for you.

Above Average Risk

The above average risk this line of liability insurance represents and the degree of expertise required to deal with it has kept most insurance companies from entering the market. Currently only about a dozen insurance companies provide medical malpractice insurance coverage. I am uncertain how long any of us can continue. The conditions under which we market and service this business have deteriorated so much that in 1975 some doctors in some states may be unable to purchase standard malpractice coverage at any price.

There probably isn't a higher incidence of malpractice today; it's just that more patients elect to sue today.

This has sharply increased your malpractice insurance premiums, almost destroyed the availability of the coverage and increased health care costs for consumers.

Government Intervention?

If the malpractice crisis cannot be solved, it may develop that the only source of financial protection for you will be a government system. Whether a federal program or 50 state funds, government intervention almost certainly will increase government's attempts to tell you how to practice medicine.

The question in our company, and surely in any company trying to deal with the malpractice crisis, is whether we will be able to stay in the medical liability business long enough to apply corrective solutions and see results. We now insure 48,000 doctors, 17 per cent of those in the country. Like any company, we are limited as to how much of our insurance capacity we can allocate to any one line of insurance. At the present time we do not have the capacity to take on any new medical liability policyholders, except in the states where the state medical society sponsors us as its endorsed insurer. Original acceptance of sponsored status on our part implies a general acceptance of new policyholders. Of course we will write a doctor when he joins a partnership, professional corporation or other professional organization which we currently insure. We continue to renew existing policies, except in states where regulatory authorities are not permitting us an adequate rate. Without an opportunity for a modest profit, and facing a certain loss, it would not be sensible for us to continue with this business. We recognize that rate increases are not the final answer to the malpractice crisis, but they buy time to develop and implement what we hope are the answers.

Why Suits Occur

Identifying the problems has not been easy. We have heard suggestions that the malpractice crisis could be solved if doctors would do a better job of policing their own profession, weeding out the incompetents. This may be the biggest obstacle of all to solving the problem—the assumption that while all doctors are harassed by plaintiff attorneys, only the incompetent commit malpractice. The truth is that the most highly qualified doctor in this audience can lose a malpractice claim because malpractice is what the law says it is, not what you think it is. Any one of you here today can face a malpractice allegation. Not because you are incompetent, but because the practice of medicine is complex and getting more complex. Because mistakes can happen even under the most competent practitioner. Because new techniques and drugs save lives that would have been lost before, but at the same time

* President, St. Paul Fire and Marine Insurance Company, 385 Washington St., St. Paul, Minnesota 55102. From a speech delivered before the American Academy of Ophthalmology and Otolaryngology, October 10, 1974. Reprinted with permission of The St. Paul Companies, Inc.

bring new risks. Because patients believe that modern medicine can cure just about anything and therefore expect more from their doctors. Because consumerism has educated patients to understand that a lawsuit is simply another means of gaining redress of their grievances, whether real or based on imaginary harms. Because some doctors and patients have lost the close rapport that once both enjoyed. And, because changes by the courts in negligence law are steadily eroding many of your standard and traditional legal defenses.

Last year we established a special department to research and introduce ways of preventing malpractice incidents, to help doctors explain to patients the hazards of medical treatment and to speed up and simplify claims settlement procedures to reduce the high cost of legal defense and other claims costs.

We developed a better method of isolating the types of claims and the causes of them. We now have a computerized, detailed quarterly report on causes of loss. This provides us with information, by state and by each county within the state, on each individual malpractice claim. It tells us the allegation being made in each claim, the specialty involved, the date of alleged injury and the date the claim was reported to us. This information is summarized by specialty and by allegation. With this data we can track trends in specialties by geographic areas by cause of loss.

When We Win, We Lose

Malpractice cases are expensive to settle. The legal defense costs are unusually high because of the time involved in investigation, pre-trial work, attempts at settlement and the trial itself if the case goes to trial. In one of our cases, the claimant sued for $75,000. We won the case, but it cost us more than $10,000 to defend. Another case we won involved a claim for $1,700,000. It cost us $28,000 to defend. In one sense, even when we win, we lose.

So, we have been investigating less costly and quicker claim settlement practices. To us, binding arbitration offers the most promise for speeding up the disposition of claims, thereby reducing settlement and legal defense costs, and of overcoming jury decisions based on emotion instead of law and facts.

Medical arbitration generally works in one of two ways:

An agreement may be reached between the plaintiff and the defendant to arbitrate an existing claim. If a lawsuit has been filed, it can be removed from the court docket and placed into arbitration. The other and more popular method is initiated by the patient signing an agreement, as part of his admission to the hospital, to arbitrate any future dispute. The patient has the right to retract the agreement within 30 days of his dismissal from the hospital. Admission to the hospital is not refused if the patient declines to agree to arbitration, and arbitration is not used for emergency room admissions.

Arbitration plans call for the formation of an arbitration panel, ideally composed of a lawyer familiar with medical liability litigation, a doctor in the specialty of the defendant doctor and a lay person.

There is only so much that we or any insurance company can do to alleviate the malpractice crisis. What we can do will not be adequate even to maintain the availability of malpractice insurance from private companies, much less to stabilize insurance rates. If this financial protection is going to continue to be available, there are some things that you must do as individuals and there are things your associations must do.

What You Can Do

First, you must accept the fact that malpractice claims do not happen to someone else. There but for the grace of God go you.

Patients lack an appreciation of the complexities and hazards of medical practice. They undervalue the risk and assume there has been negligence when the outcome of their treatment is less than they expected. Many doctors are reluctant to describe fully the possible ill effects of a treatment or surgery. The result is that many patients tend to blame their doctors if results are less than hoped for. There must be an increased rapport between the doctor and the patient. There must be increased and improved flow of information from you to your patients and an improved listening on your part to your patients' concerns or unexpressed worries. That a patient does not express concern to you or does not ask questions about the nature of the illness or the risk of treatment or the prognosis of his ailment does not mean that he does not have questions or worries. It does not mean he does not want information. Most patients, I suspect, would prefer that the doctor volunteer information rather than for the patient to have to ask the right question. In some cases the patient simply may not know the right question. It is your responsibility to ascertain from what the patient says and does not say and how he acts as to what he wants to know. In addition to being healers of the body, you must become communicators.

It takes time. It means frustration in trying to communicate a complicated medical procedure. But you do your patient no service if he leaves your office assuming a guarantee of successful treatment. You do your patient no service by failing to inform him of the common and inherent risks of any operation or procedure.

You also must be willing to serve on medical peer review groups. Under peer review, one doctor or a panel of doctors examines a malpractice claim and provides an opinion to the insurance company as to whether the defendant doctor did or did not depart from the standard of care. Insurance companies have claims people with the expertise to identify many claims that are clearly defensible. They can also determine many situations where the doctor has in fact departed from the standard of care. However, there are many cases in the middle—the gray area—where claims people need expert help. Peer review panels speed up the loss settlement process in questionable cases. The longer cases remain open, the higher the cost of settling them and the greater effect that inflation has on the ultimate settlement figure.

Remedial Legislation

We must consider what remedial legislation is necessary to prevent the complete collapse of legal defenses. You, the public and legislators must recognize that doctors cannot be expected to be infallible and there must be some protection under the law.

According to common law, a doctor is held respon-

sible for following the accepted standard of medical practice in his own community. This is called the locality rule. If he adhered to this standard, the doctor could not be held liable.

Today plaintiff attorneys are bringing in paid medical witnesses for all parts of the country, in all specialties, to testify as to the standard of care the local physician should have followed. Their excuse is that local doctors won't testify against colleagues.

We agree an injured party should be able to obtain competent medical testimony on a legitimate case of negligence. However, this "conspiracy of silence" argument often used by plaintiff attorneys frequently translates into the fact that an attorney simply was not able to find a local doctor whose medical opinion agreed with the attorney's legal conclusion. In our estimation, a plaintiff with a legitimate claim has little trouble obtaining adequate local medical testimony. Remedial legislation is needed to restore and retain the locality rule.

The statute of limitations continues to be extended. In other kinds of negligence actions, the statute runs from the date the injury occurred. In medical malpractice, many states apply a discovery rule. This means the statute does not begin to run until the patient discovers the alleged injury, which may be years after the treatment.

Extension of the statute of limitations places an undue burden on the doctor and the insurance company. We see some evidence that this burden is being recognized. Canada recently reduced the permissible number of years for legal action from 30 years to 1 year. Alaska and Florida also significantly shortened the time period. More action of this nature is necessary.

Another area of needed legislation deals with the confidentiality of peer review groups. Legislation is needed to grant these groups immunity from legal action brought by a colleague who the panel has determined was not following good accepted practice.

Informed Consent

A growing legal and communications problem for doctors revolves around the doctrine of informed consent. It is a basic principle of our society that every man has the fundamental right to the physical security and integrity of his body. In the past the physician was protected from an allegation of malpractice if he could show the patient had consented to the specific treatment or operation and that the patient was competent in the eyes of the law to give such consent. In many states, court decisions have steadily expanded what the doctor must tell the patient in order to secure true informed consent. In some states the doctor must inform the patient of virtually every conceivable risk, no matter how remote. The theory is that the patient should be able to make an intelligent choice from the possible courses of treatment or refuse treatment altogether.

We agree with that theory. But we also believe some reasonable standards should be established by law as to how far a doctor has to go to cover the risks.

These are four examples of needed remedial legislation. There are others. We have not drafted new legislation and we have not lobbied for particular bills. Our role is to define the problem, explore the remedial action, bring this information to the attention of those groups best able to influence legislatures and help them in whatever ways we can. We believe that the medical profession is in a much better position than we are to present the case and lobby for it.

Remedial legislative effort probably will come primarily at the state level. But it is inevitable that we will have some kind of national health insurance act which will provide broader health care. It should be worthy of your attention to explore how this national health insurance act could encompass reasonable protection under the law.

Seize the Initiative

Here is an opportunity for you to seize the initiative . . . organize yourselves in every state . . . determine what your local legal situation is . . . then set a course of action to correct the problems you're facing.

We are eager to work with any group interested in solving the malpractice crisis. Action at this point is more important than words. Time is running out in terms of an available and free market for medical malpractice insurance.

We need each other. We want to stay in this market. We are leaders in this coverage and we want to maintain that position if possible. But, we have to have the expectation of profit to enable us to continue.

For yourselves, you need the protection this coverage provides. And, without the private market for malpractice insurance you are reasonably left with the alternative of governmental programs. The private insurance market provides the opportunity to practice medicine with the zeal and sincerity that has been a trademark of the American medical profession.

Somehow, we have to get a grip on this problem. Alone, neither the medical profession nor the insurance industry can expect success, but together our coordinated efforts can be effective.

But wishful thinking won't solve our problems. What we do and do together will be the measure of our success. We must attack the malpractice crisis with the best of our combined talent and resources. The stakes are too high . . . for you as medical professionals . . . for us as insurers . . . and for the health care consumers . . . to do anything less. ■

Highlights of AMA House of Delegates Actions

This summary covers many of the subjects considered at the American Medical Association's Clinical Convention in Portland, Oregon November 30-December 4, 1974, but is not meant to be a complete report of all actions taken.

A mandatory, special assessment of $60 for AMA members was approved by the House of Delegates at the 28th Clinical Convention in Portland. The assessment, effective Jan. 1, 1975, for AMA members excluding students, interns and residents, is expected to improve immediate cash-flow problems and help build up depleted financial reserves.

Rejecting a $90 dues increase proposed by the Board of Trustees, Delegates instead called for a Special Committee of the House to study the dues issue and report back at the 1975 Annual Meeting.

In assessing a mandatory, $60 special assessment the House was reminded that the Association has operated at a deficit for four of the last five years, and that cash reserves have been seriously depleted during that time. In addition, AMA finances in 1974 were adversely affected by inflationary pressures.

After almost six hours of comment and deliberation on Tuesday afternoon and Wednesday morning, the Delegates adopted the $60 special assessment as a stop-gap measure.

The question of a dues increase was referred to a Special Committee of the House to be appointed by the Speaker. The committee will make a comprehensive study of the AMA's financial priorities and capabilities, and report to the House at the 1975 Annual Meeting.

In related actions, the House strongly urged the Board of Trustees to restore in a "holding pattern" the structure of several councils and committees which were to have been eliminated, and to maintain present publication schedules for *JAMA* all specialty journals, and *Prism*.

The House also approved advertising as a legitimate function in AMA publications, and urged that the present full and unrestricted advertising program in AMA publications continue pending further study and a report at the June meeting.

Professional Liability: During a discussion of malpractice problems, the House adopted a recommendation calling for the Board to give "priority attention" to providing legal counsel and advice to AMA members and state societies in the event their professional liability insurance is not renewed.

The House also emphasized the necessity for state associations to seek legislative remedies for malpractice problems, and directed that the AMA continue to cooperate with the Medical Liability Commission.

Clinical/Scientific Meetings Format Changed: A separation of the fall business meetings of the House and the scientific meetings will be permitted beginning in 1977.

Under bylaws changes adopted by the House in Portland, the House will hold its fall meeting separately in cities recommended by the Board and selected by the House, and the scientific session will hold regional meetings at other times during the year as deemed necessary by the Board and at cities selected by the Board.

The new format was devised to allow regional scientific programming. The scientific assemblies will continue to be held in conjunction with Annual Meetings, however.

In other actions on internal matters, the House:

- Called for a definitive report at the 1975 annual meeting of AMA activities and programs related to PSRO.
- Rejected a Board of Trustees proposal to replace the Council on Legislation and many functions of the AMPAC Board of Directors with a new Council on Public Affairs.
- Referred a report on direct representation in the House of medical specialty societies back to the Council on Constitution and Bylaws for further consideration.

Physicians, Hospitals and Medical Schools

Due Process: The House adopted several recommendations which reaffirm the rights of all physicians, including housestaff and medical students, to due process. In related actions, the House adopted as AMA policy the proposition that a student's academic records should be open to inspection so that he/she may profit educationally.

Guidelines for Housestaff Contracts: The House adopted a set of revised guidelines for housestaff contracts. The proposed guidelines, as revised, had been approved by the Council on Medical Education, the Board of Trustees, and the Council on Medical Service.

Biomedical Research: The House adopted a 10-point statement on biomedical research urging more federal funding with fewer restrictions. The statement sharply criticizes federal cuts in independent research grants and in the budgets of the National Institutes of Health.

The statement urges that more unrestricted grants be awarded for research; that NIH be given more independence in establishing budget and research priorities; and that appropriations for biomedical research should be in proportion to other health-related spending.

Continuing Competence of Physicians: Delegates also adopted a Board report calling for strong programs of continuing medical education and peer review as alternatives to relicensure since "the difficulties in-

herent in relicensure clearly outweigh any potential benefits."

Specific redommendations include all possible encouragement and support for the AMA, constituent societies, JCAH and other bodies in expanding CME programs; that the AMA give high priority to enhancing and reviewing effective methods of continuing competence; that patient satisfaction should be included in performance evaluation; and that well-designed peer review programs be endorsed as an important component of performance evaluation. The House also stressed that evaluation of performance, rather than knowledge per se, is the best method of appraising competence in patient care.

In other actions related to physicians and hospitals and medical schools, the House:

- Adopted an amended resolution which urges that duplication of local peer review procedures be avoided; that medical audit or utilization protocols used in screening be limited to those which are demonstrated to be valid, reliable and which do not add needlessly to cost; and that when local peer review groups recognize that a hospital medical staff has adequate medical audit and utilization procedures, that fact should be recognized by governmental agencies and JCAH.
- And requested that a "comprehensive report" be presented at the 1975 Annual Meeting on questions and issues related to foreign medical graduates.

Physicians and the Government

National Health Insurance: The House adopted a report containing basic guidelines for NHI deliberations.

The guidelines include minimum federal involvement in the administration of any NHI program; state jurisdiction for licensure of physicians and regulation of insurance; no Social Security tax financing and administration of any program; funding through federal revenues, state revenues, and private funds including employer-employee contributions for private health insurance; comprehensive coverage for basic and catastrophic needs; and the maintenance of pluralism in health delivery.

Manpower and Planning Bills: The House adopted an emergency resolution expressing unanimous opposition to U.S. House of Representatives bills which would divide the nation into health service planning areas and treat health care as a public utility, and which would require medical students to reimburse the government for capitation.

The resolution was unanimously adopted and its substance presented to House Speaker Carl Albert and other Congressmen.

Prepaid Plans and Bonuses: Delegates adopted a Judicial Council report which cautions that the payment of bonuses to physicians in prepaid health care plans such as HMOs for minimizing the utilization of services may interfere with the physician's obligations to his patients.

In other actions related to physicians and the government (and third parties), the House:

- Encouraged the acceptance and use by physicians of the AMA's Uniform Health Insurance Claim Form, and urged insurors to study the possible use of plastic "charge card" type identification cards for imprinting basic data on insurance forms.
- And urged the government to continue its present 55 m.p.h. speed limit for at least a one-year period, noting that traffic fatalities have declined 14.8 per cent since the speed limit was imposed last year.

Physicians and the Public

Weight Reduction Clinics: The House took a strong policy position against the use of human chorionic gonadotropin for use in weight reduction. The House further resolved "that the AMA warn our citizens about the potential danger of such a weight control program." Clinics utilizing chorionic gonadotropin have been established and widely advertised in various parts of the country.

In other actions relative to physicians and the public, the House:

- Supported state legislation to regulate the practice of acupuncture. The new policy says acupuncture should only be performed in research settings by a physician or under the direct supervision of a physician.
- Adopted a Judicial Council report which holds that, "It is not unethical for a physician to authorize the listing of his name and practice in a (community) directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills or competence."

Report of the AMA President

The price of defending medical freedom can be high, but that price must be paid, AMA President Malcolm C. Todd, M.D., told Delegates at the Clinical Convention in Portland.

Equating the "freedom that has made American medicine the most creative in the world" with the "very essence of professionalism cherished so highly by the nation's physicians," Dr. Todd pointed out that medicine's freedom, and hence its professionalism, are threatened.

Chief among the threats are various legislative proposals which would impose a compulsory national health insurance system, would make health care a public utility to "reduce each of us to the level of an electric wire or a telephone line," and manpower bills that would "imply indentured service in medical education."

Only a strong AMA can counter such threats and preserve professionalism, Dr. Todd emphasized, but "it is impossible for its strength to be any greater than its finances."

Therefore, he issued a strong appeal to the House to support a $90 dues increase, or, as an alternative, a special assessment.

While admitting that the AMA was not 100 per cent effective legislatively, he said that, "No element in society has a perfect score. Any element has to set its sights not on the best of all possible worlds, but the best of all possible realities."

". . . I leave you with two questions: Is the survival of our profession in danger? I say that it is. Is a dues increase the necessary price that we must pay for our survival? Again, I say yes." ■

The Pluralistic Approach

ECONOMICS HAS BECOME a common word in our current lexicon. We are all concerned with recession, depression, deficits, and excess profits (a curiously redundant phrase). What with the federal government filing suit against AT&T, one begins to wonder—"Is anything sacred?" All of which leads to the question of the economics of medical care. Indeed almost a sacred subject, since there is little written about the general economics of the delivery of medical care. Much is said about the cost of medical care, but discussions concerning the medical marketplace and the variables influencing the various costs are usually limited to a presentation of a particular opinion. Yet there seems to be much lip service paid to the pluralistic approach to the delivery of medical care when the discussion is actually aimed at a specific method.

Prepayment—Nothing New

It would appear that the initial push for the formation of Health Maintenance Organizations has come from the premise of experimenting with various new forms of medical care delivery. It should be apparent that there is nothing new about the form of delivery utilized in HMOs. Whatever label is applied, the common thread in HMOs is that medical care is prepaid—or, more explicitly, a specific amount of money is delivered for whatever services might be performed at a later date.

This represents nothing more than a method of financing medical care and not a new method at that. This principle of financing has been utilized for years, however, it looks like now it's going to get a new push. As part of a multipronged approach to gain total control over medical care in the United States, HMOs are being revived. It is important to look at the other prongs since therein lies the impetus for this "new" method of financing.

Part of the Big Picture

The first of these thrusts was the beginning of our current problems—passage of the Medicare-Medicaid insurance legislation—a foot in the door based on emotional appeal. The second is the now current PSRO-HMO activities—a more in-depth involvement into regulatory (PSRO) and cost control (PSRO and HMO) activities. The third is now being drafted. These involve "health manpower" legislation (HR16204, HR17084, and S3585), with regulatory powers over medical personnel and facilities. And the final icing on the cake—total financing with the fourth thrust (read shaft)—National Health Insurance. With an overall prospective of these multiple inroads into medical care, one begins to see the importance of making certain that each thrust(?) is successful.

Prepaid medical care has been mildly successful in the past, usually in the areas of homogenous population or small groups of relatively healthy people. Specific examples are available in the Far West and occasional metropolitan

areas. It has never been able to supplant the private practitioner or the free market system of medical care without some form of special legislative treatment. Why? I expect for the same reasons that a controlled economy has never been able to provide better means than a free market economy.

What then, should we do about HMOs? I say—Leave them alone! If they can provide better care, the patients will flock to them; if they can't, the patients will ignore them. But above all, do not give them favored legislation. This is blatantly unfair to the patient—deluding them into believing the prepaid system is better when its position is based on special legislation utilizing tax dollars, thus making our patients pay twice for the care received. If we are truly interested in the pluralistic approach to medical care, then now is the time to take off the wraps, lay out the facts, and allow each method to seek its own level.

W. Daniel Jordan, M.D.
490 Peachtree Street, N.E.
Atlanta, Georgia 30308

DETAILS ON KEOGH DEDUCTIONS CLARIFIED

MAG legal counsel J. Winston Huff has clarified some points concerning the increase in Keogh deductions under the new federal tax law and the need of amending the Georgia law to come in line with this increase. This information was sent to presidents and secretaries of county medical societies and the Executive Committee in late December, and is repeated here because of widespread interest in and misunderstanding of the subject.

Until September 1, 1974 the maximum deductible contribution to a Keogh plan under federal tax law was $2,500 per year. This was recently changed and increased to $7,500 per year.

The Georgia income tax law simply adopts the federal tax law by reference. Unfortunately the General Assembly must update this each year. As of now the Georgia law refers to the Federal Internal Revenue Code as it existed on January 1, 1974 and thus still allows only a $2,500 deduction.

The news items that have appeared in the *AMA News* and other publications on this problem, Huff says, are misleading, in that they say that a contribution in excess of $2,500 may "disqualify" the pension plan. This is not so. The plan will not be disqualified under the federal law. Unless the Georgia law is changed, the excess payment into the plan over $2,500 may be "disqualified" as a deduction on the Georgia income tax return, but the plan is otherwise unaffected. You will still get the full federal deduction for the tax year 1974 up to $7,500 or 15 per cent of compensation, whichever is less. This view by Mr. Huff was confirmed by Mr. Bernard Hirsh, general counsel of the American Medical Association.

MAG is working to see that a bill is drafted for presentation to the 1975 Georgia General Assembly which would retroactively increase the Georgia deduction to coincide with the federal deduction.



Learning by doing is the philosophy behind this workshop on intubation led by Robert F. Finegan, M.D. (R), anesthesiologist at South Fulton Hospital. This workshop and others on interpreting x-rays and EKGs were part of the three-day course on "Stabilizing the Emergency Patient" held at the Atlanta Internationale Hotel in December. Co-sponsors of the program were The Georgia Chapter of the American College of Emergency Physicians and the Georgia Society for the Prevention of Blindness.

president's letter

The Mettle of Our Leadership



ONE IDEA INHERENT IN THE SUBJECT of this month's *Journal* is the team concept of the practice of medicine. This embodies the utilization of various health professionals in the delivery of health care in order to make this process more effective and efficient. Many problems are associated with the implementation of this concept, however.

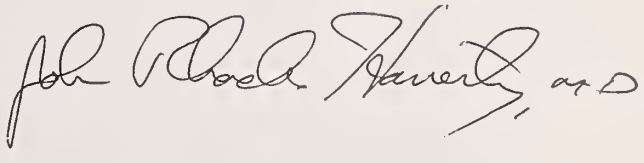
Dr. Edmund Pelligrino once stated, "Perhaps the biggest scandal of all to the public is the scant evidence they see of a cooperative endeavor among all of us who purport to provide health services." This quotation related to the divisiveness among allied health professionals, but it also relates clearly and accurately to the division and confusion found among allied health professionals and other health professionals such as physicians, dentists, nurses and pharmacists.

If the public is to be served well, health professionals must work together. Each of these professionals has much to offer. Physicians are accepted as the responsible link between those who are not well and those who are. Nevertheless neither physicians nor other health professionals including allied health professionals can function in an effective way independently in America today. There is necessarily an interdependence of the various professions with each other. Dr. Malcolm Todd has stated, "The collaboration roles played between the physician and allied health professionals in health care delivery now constitute what might be called a professional marriage."

At a recent meeting in New Orleans, I took over as president of the American Society of Allied Health Professions for the year 1974-75. At that meeting, as at other allied health professional meetings, there was an underlying anxiety and mistrust of the physician role as it relates to other health professionals. Since it has been traditional for the physician to be the leader of the health care team, it falls upon the shoulders of medicine to lead in the resolution of these anxieties that interfere with the best health care of our people. We must help allay feelings of mistrust by finding proper solutions in providing effective interdisciplinary care.

We must help work out the relationships between nurses and physicians and between allied health professionals and physicians at the local level. If we go back to the basic premise which all of us recognize as the motivating force for our existence—the betterment of the health of those who seek our services—we can but rededicate ourselves toward our mutual interdependence in that service. We must trust each other to share the same motivation and altruism we proclaim for ourselves. If we can proceed with these thoughts in mind, and work at the true interpersonal level, then some of the organizational difficulties and estrangements can begin to be solved.

If we are the leaders we proclaim, let us now show the mettle of our leadership. Let us find ways of ensuring cooperation among members of the health care team in a delivery system that will benefit the patient. If this can be accomplished, then the mode of practice will be of little consequence—whether it be office based, fee-for-service, hospital, or HMO.



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

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cancer page

Fiberoptic Colonoscopy— Early Diagnosis of Colorectal Cancer

R. CARTER DAVIS, JR., M.D., *Atlanta**

THE INCREASED INCIDENCE of colorectal cancer demands better diagnostic methods and facilities to accurately diagnose lesions at an earlier stage. The standard evaluation of patients with colonic symptomatology includes a medical history, physical examination, rectal examination, stool guaiac, proctosigmoidoscopy and barium enema examination; however, in many instances this has proven to be inadequate in diagnosing early lesions. Pioneer endoscopists with advance technology have brought the field of gastrointestinal endoscopy to the aid of the practicing physician. Throughout the entire country a growing interest in and awareness of the procedure is apparent—but many still wonder why, when, where and if they should seek this new diagnostic modality.

The acceptance of colonoscopy as a diagnostic and therapeutic technique is inevitable. More and more people are seeking information about the procedure. As more individuals are being trained in this field, their judgment and experience take on more depth, all to the end of increased accuracy, efficiency, and safety in the practice of medicine. If used in the proper clinical situations, colonoscopy can provide a definitive diagnosis in those patients whose history, sigmoidoscopy and barium enema do not properly or fully explain the signs or symptoms being evaluated. The findings at colonoscopy clearly define the abnormality that may be suspected on x-ray; more specifically, the exact nature of the lesion is ascertained by direct visualization, biopsy, cytology, and can be documented with still photography or cine. Fiberoptic colonoscopy is not a routine procedure and is most often done in the inpatient setting. The examination requires a significant amount of patient cooperation and preparation prior to the examination as well as a patient and skilled endoscopist.

Seven Major Indications

The major indications for colonoscopy at this time are seven:

1. X-ray negative patient—patients with persistent colonic symptomatology: rectal bleeding, prolonged diarrhea, significant weight loss, persistent positive stool guaiacs and/or iron deficiency anemia.

2. X-ray questionable (nonspecific) lesions—persistent filling defects, strictures, narrowing and incomplete filling, "diverticulitis, cannot rule out possible carcinoma."

3. X-ray positive patient—patients with one radiologically proven lesion or malignancy should be screened for other metachronous lesions preoperatively or intraoperatively before a limited surgical resection is considered.

4. High risk group—Longstanding chronic ulcerative colitis, Gardner's syn-

* Dr. Davis is an internist whose practice is at 1201 Peachtree St., N.E., Atlanta, Ga. 30361.

drome, familial polyposis, previously resected colon carcinoma, and patients with strong family history of colorectal carcinoma.

5. Polyps—at the present state of our knowledge and expertise, there is no need for laparotomy and colotomy to remove polyps since colonoscopic polypectomy is safer, requires less time, and is much less expensive. In experienced hands, virtually all pedunculated polyps and many sessile polyps can be excised easily from any area of the colon.

6. Follow-up examinations—Because of the increased incidence of subsequent carcinoma and repeat polyp formation, any patient who has had prior polypectomy should be examined periodically. This also holds true for patients with previously resected colorectal carcinoma.

7. Research applications—Physiological studies to investigate diverticular disease, follow-up on results of chemotherapy in colorectal carcinoma and inflammatory bowel disease.

Fiberoptic colonoscopy is finding its way into standard everyday clinical practice. It is hoped that this promising new modality will not have its reputation tarnished by misapplications and abuse which will lead to an inordinately high complication rate. Suitable training programs are lacking, especially for those who have completed their training; however, efforts by the American Society for Gastrointestinal Endoscopy and the American Cancer Society are underway to correct this. ■

CONTINUING MEDICAL EDUCATION OPPORTUNITIES

HUMAN DISEASE RELATED TO FOOD AND CHEMICAL SENSITIVITY
January 29-31, 1975
Americana Hotel, Bal Harbour, Florida
Contact: Division of Continuing Medical Education,
University of Miami School of Medicine
P.O. Box 520875 Biscayne Annex
Miami, Fla. 33152, (305) 547-6716

CURRENT COMPUTER APPLICATIONS IN MEDICINE
January 31-February 1, 1975
Flagler Inn, Gainesville, Florida
Contact: Dr. Bernice S. Scott, Continuing Education
807 Seagle Building
Gainesville, Fla. 32601, (904) 392-2317

SIXTH ANNUAL FAMILY PRACTICE REFRESHER COURSE
February 9-15, 1975
Mills Hyatt House Hotel, Charleston, South Carolina
Contact: Dr. Vince Moseley, Director
Division of Continuing Education
Medical University of South Carolina
80 Barre St., Charleston, S.C. 29401

ACOG DISTRICT IV ANNUAL CONTINUING EDUCATION CONFERENCE
February 17-19, 1975
Fairmont Colony Square Hotel, Atlanta
Sponsored by the AMA and the American College of Obstetricians and Gynecologists
One East Wacker Dr., Chicago, Ill. 60601

1975 SOUTHEASTERN SURGICAL CONGRESS ANNUAL ASSEMBLY
February 17-20, 1975
Hyatt Regency Hotel, Atlanta
Postgraduate Course on "Cancer of the Breast" on February 16
Contact: SSC, 340 Boulevard N.E., Atlanta, Ga. 30312

BASIC NEUROLOGY FOR THE PRACTITIONER
February 20-21, 1975
Medical College of Georgia, School of Medicine
Augusta, Ga. 30902

PEDIATRIC BEHAVIOR MANAGEMENT CONFERENCE
February 21-22, 1975
Contact: Division of Continuing Medical Education
University of Miami School of Medicine
P.O. Box 520875 Biscayne Annex, Miami, Fla. 33152

DIAGNOSIS AND TREATMENT OF ACUTE AND CHRONIC RESPIRATORY FAILURE
February 24-28, 1975
Miami Beach, Florida
Contact: Bradford W. Claxton, Director
Continuing Education
American College of Chest Physicians
911 Busse Highway, Park Ridge, Ill. 60068

CLINICAL PSYCHIATRY
February 27-28, 1975
Medical College of Georgia, School of Medicine
Augusta, Ga. 30902

PULMONARY SYMPOSIUM II, THE PRACTICAL USE OF RESPIRATORY CARE
February 27, 1975
Holiday Inn of Callaway Gardens
Pine Mountain, Georgia
Sponsored by the West Georgia Chapter of
the Georgia Lung Association and the Georgia Society for Respiratory Therapy

heart page
heart page
heart page

Early Ambulation and Hospital Discharge After Myocardial Infarction

I. W. JOINES, II, M.D., *Atlanta**

IN THESE TIMES OF RAPID PROGRESS in the study and practice of medicine a dilemma of major proportion exists in the management of acute myocardial infarction patients. Despite the apparent benefits of early mobilization and lack of adverse effects from early discharge and return to gainful work in selected, low-risk patients, many physicians continue to follow rigid programs which unnecessarily prolong bed rest, limit ambulation, delay discharge and impede return to reasonable activities. These facts are all the more worth attention due to the mounting costs of coronary care from pre-hospital care to in-hospital days and through the post-hospital period of convalescence and gradual return to previous living patterns or maximum levels of recovery. The implications of PSRO, utilization review and governmental certification of need procedures now being formulated, further demand that medicine as a whole, focus its attention on the matter and endeavor to resolve the problem.

Hutter and associates, in a prospective, randomized study, compared a two-week and three-week hospital stay in 138 patients with uncomplicated, but definite myocardial infarctions and concluded from a six months follow-up that no difference existed at that time between 69 patients in each group in frequency of return to work, anxiety or depression, development of angina or congestive heart failure, ventricular aneurysm formation, coronary insufficiency, reinfarction or death.[1] Bloch and associates completed a similar study which further showed no differences between such groups in results of an exercise test. However, greater disability was noted in the control than in the early ambulated, treated group on follow-up.[2]

Wilson and Partridge have attempted to reduce monitoring time by assessing, among other risk factors, ST segment displacement 48 hours after infarction. In those patients with 2 mm or less of ST displacement from the isoelectric line at the end of 48 hours (and with no hemodynamic or conduction disturbance, delayed atrial fibrillation, persistent sinus tachycardia, pronounced SGOT rise or reinfarction) no significant late ventricular arrhythmia occurred.[3] This data, if accepted, would suggest that fully one-third of patients admitted to a hospital coronary care unit with an acute myocardial infarction do not require monitoring after 48 hours.

Early Discharge Risk Factors

A consideration of various risk factors against early hospital discharge includes the following:

1. Significant arrhythmia during monitoring period (ventricular tachycardia, PVC's heart block or bundle branch block);

* Dr. Joines is an internist in practice at 490 Peachtree St., N.E., Suite 567-C, Atlanta, Ga. 30308. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

2. Sinus tachycardia of one hour's duration or more in the first 48 hours;
3. Persistent ST segment elevation (not returned to 2 mm or less in one week);
4. Recurrent ischemic pain requiring opiates;
5. Recurrent arrhythmia (occurring after 48 hours);
6. Congestive heart failure.

Obviously the list could be expanded to encompass the psychiatric and socio-economic spheres. Late sudden death occurs more commonly after anterior left ventricular infarctions, frequent early ventricular tachycardia or left ventricular failure.

A recent retrospective study over a 30 year period shows that there has been a large increase in the number of clinical laboratory tests, roentgenograms and bacteriological examinations, also, more electrocardiograms, sedative drugs and days of oxygen therapy (not to mention the vast sums invested in constructing and equipping coronary care units). However, no significant changes in duration of hospitalization or in-hospital mortality have been realized.[4] In most university medical centers and large teaching hospitals, the average in-hospital stay has been reduced to less than two weeks in uncomplicated myocardial infarctions (in many, the average total number of days is 10).

Prolonged hospitalization based largely on past patterns of empiricism must be avoided and earlier discharge effected in light of new data suggesting that myocardial infarction patients will not be harmed and, indeed, may be helped in achieving earlier, fuller rehabilitation. ■

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2. Bloch, Antoine, Maeder, Jean-Pierre, Haissly, Jean-Claude, Felix, Jose and Blackburn, Henry: Early mobilization after myocardial infarction; *Am. J. Card.* 34:152-157.
3. Wilson, C. and Partridge, J. F.: ST segment displacement and early hospital discharge in acute myocardial infarction; *Lancet* 2:1284-1288, 1973.
4. Martin, S. P., Donaldson, Mc., London, C. D., Peterson, O. L. and Colton, T.: Inputs into coronary care during 30 years; *Annals of Int. Med.* 81:289-293, 1974.

HIGHLIGHTS OF EXECUTIVE COMMITTEE
December 2, 1974

Concurrent Hospital Review: Received report on progress of meetings to establish a uniform concurrent hospital review system in Georgia for Medicaid, Medicare and others.

Unified Membership: Approved request for Constitution and Bylaws Committee to prepare language requiring MAG membership for county medical society members.

Community Based Cancer Control Program: Authorized submission of a contract proposal contingent upon receiving support from interested organizations.

SEER Program: Adopted reporting procedure for director of the SEER Program to MAG executive director.

Georgia Medical Care Foundation: Received report concerning the Department of Human Resources funding ($6,000) for the pilot CHEC program.

Appointments: Committee to Study Physician Assistant Programs, William J. Morton, Chamblee. Ex officio members, Leon E. Curry, Metter; John P. Heard, Decatur; George Green, Sparta; Ollie O. McGahee, Jesup; Thomas F. Vigorito, D.O., Tucker; John R. Palmer, Augusta, and Mr. David Glazer, Atlanta.

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I've told this before . . . .

(Ed. note: A frosty, moonlit night—perfect for a possum hunt, till the hounds suddenly decide it's time to head home. Author J. G. McDaniel, M.D., explains why in this month's story. Other MAG members and their families are invited to submit copy for this feature page, which should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Possum Hunt

DURING MY HIGH SCHOOL DAYS in the late teens, there were several of us who enjoyed hunting. It didn't make too much difference what we hunted. I guess it was a way of burning excess energy, which we had plenty of.

We kept hearing about a tenant farmer who lived out on Gum Swamp by the name of Elijah Harrell. Everybody said that "Lige" had some of the best possum dogs in the county.

For some reason, Lige was not gung-ho on taking us hunting. It may have been that he was just plain smart, because after we had promised to carry the axe, cut down any tree that we had to and carry any possums that we caught in a croker sack and give him the possums, he said that he would take us the next Saturday night.

Saturday night turned out to be a thing of beauty. It was in the fall. We had already had a light frost, the wind was not blowing and it was cool and crisp. The moon was bright enough for us to walk without a lantern or flashlight.

Lige had three dogs—two old ones and a young one in training. We walked down the road for about a half mile, then turned off into a piney wood area where Lige said there were lots of persimmon trees and if there is anything that brother possum loves it's ripe persimmons.

We had not been more than 10 minutes in the woods when one of the old dogs sounded off, then the other two joined him. They trailed for about five minutes, then barked "tree." When we got there we could see Mr. Possum up in the top of a small persimmon tree. One of us climbed up about half way to the top and shook the tree so vigorously that the possum fell out. The dogs were on him like a flash, shook him a few times and, although they hurt him very little, he lay there like he was dead as a doornail. We had not carried him in the sack more than a few minutes when he miraculously came to life.

We were now hunting on the edge of a good sized branch when one of the old dogs opened up on a fairly hot trail and for something like 10 or 15 minutes the three of them gave some ecstatic vocalization heard nowhere except occasionally in grand opera.

They had treed up a fair-sized evergreen tree and for the life of us we could not see anything up that tree, but we had a poor flashlight and as Lige pointed out, he could be anywhere hidden in a clump of leaves. We were all for cutting it down, but Lige vetoed it. We could not climb very high in the tree and kept insisting that we cut it down. The tree wasn't any good for anything we could think of. Lige kept saying, "No, no, no" . . . and finally suggested that we just leave and go on with the hunt. That was more than one big ole hard-headed boy could stand and he commenced cutting on the tree.

On the second lick with the axe, the dogs checked out as if something were after them and no amount of calling would bring them back. When we got home the dogs were under the house and would not come out. Lige could not or would not give us any clue to that strange episode.

Some months later, I was talking to a first cousin of Lige's and he gave me

the "poop." It seems that when his old dogs were young and had just commenced being good possum dogs, they ran across a big old boar coon and took off after him with so much vim and vigor that Mr. Coon was forced to go up a small tree. Lige, thinking it was a possum, cut the tree. As soon as it fell, the young hounds tackled this varmint with great enthusiasm, but instead of finding a docile animal, they encountered a buzz saw and before they could get out of the tree top, their noses and ears were bleeding in a dozen places. Since that time they will run and tree a coon, but you must shoot him out of the tree. If the tree is touched with an axe, the dogs head for home and hide under the house. The hunt is over.

J. G. McDaniel, M.D.
820 W. Wesley Road, N.W.
Atlanta, Georgia 30327

Cobb Symposium Examines "The Human Condition in 1975"



Calderone



Slovenko



Kubler-Ross



Pollard



Allison



Mead

The 10 year anniversary program of Cobb County's interdisciplinary Symposium next spring will see the return of speakers such as Margaret Mead and Elizabeth Kubler-Ross from previous programs, who will explore "The Human Condition in 1975."

Co-sponsored by the Cobb County Medical Society and its Committee on Medicine, Law and Religion, and Kennesaw Junior College, Cobb County Bar Association and Cobb Ministerial Association, Symposium '75 will be held Thursday and Friday, April 10-11, 1975 at Kennesaw Junior College and the Fairmont Colony Square Hotel.

This 10th anniversary program is being dedicated to the memory of Dr. Albert Schweitzer (1875-1965), one of the great interdisciplinarians—physician, theologian, musician and philosopher—on the century anniversary of his birth.

Dr. Mary S. Calderone, pioneer in sex education, will open the Symposium Thursday evening discussing "Human Sexuality—Source of Energy, Source of Change." Completing the program that evening will be Ralph Slovenko, LL.B., Ph.D., from Wayne State University, examining the question, "Can Law Control Crime?"

Friday morning Dr. Elizabeth Kubler-Ross, noted for her counseling of terminally ill patients and author of the best seller *On Death and Dying* speaks on "What Is It Like to Be Dying?" William G. Pollard, Ph.D., D.D., internationally known nuclear physicist and Episcopal priest will discuss the subject, "Are Science and Religion Compatible in 1975?"

Symposium participants Friday afternoon will be divided into groups for informal question and answer sessions with the speakers, after C. Fitzsimmons Allison, D.D., Ph.D. of Alexandria, Virginia has summarized the comments of the speakers.

A closing dinner program at the Fairmont in Atlanta will feature anthropologist Dr. Margaret Mead whose topic is "The Human Condition—The Struggle for Identity."

For additional information, write the Office of Community Relations, Kennesaw Junior College, Marietta, Ga. 30060 or call (404) 422-8770. Program sponsors have applied to the American Academy of Family Physicians for nine elective hours.

the association
the association
the association

NEW MEMBERS

Chang, Lung-Hsiung DeKalb—Act—Oph	1300 W. Pike Plaza Lawrenceville, Ga. 30245
Copeland, Frank M. Bibb—Act—P	Med. Center of Central Ga. Macon, Ga. 31208
Flournoy, Henry W. Glynn—Act—ObG	2444 Parkwood Dr. Brunswick, Ga. 30520
Frolich, David J. Bibb—Act—I & R	752 Hemlock St. Macon, Ga. 31201
Gowen, James F. Glynn—Act—ObG	2444 Parkwood Dr. Brunswick, Ga. 31520
Phelps, Paul R. Bibb—Act—Su	781 Spring St. Macon, Ga. 31201
Sergent, Paul M. Cherokee-Pickens—Act—FP	200 Marietta St. Canton, Ga. 30114
Spear, J. Louis Hall—Act—R	Hall County Hosp. Gainesville, Ga. 30501
Spivey, James W. Peach Belt—Act—Or	124 Hospital Dr. Warner Robins, Ga. 31093

SOCIETIES

Baldwin County Medical Society has a new slate of officers: Samuel Goodrich, president and MAG delegate; James Baugh, vice-president; Perry Moore, secretary; William Howard, treasurer.

At the November meeting of the **DeKalb County Medical Society** 1975 officers and delegates were selected: Lawrence L. Freeman, president; LaMar S. McGinnis, president-elect; Stanley P. Aldridge, vice-president; Charles W. McDowell, Jr., secretary-treasurer; Clyde Rountree and Jay S. Coffsky, junior trustees; Luther M. Vinton, Jr., MAG councilor; Stanley P. Aldridge, vice-counselor; Richard H. Smoot, Dr. Freeman and Timothy Harden, Jr. to three year terms as MAG delegates and William Rawls, Kenneth A. Hoose, Jr. and James C. Joiner as alternate delegates; George R. Jones, director to the Georgia Medical Care Foundation, with William R. Hardcastle as alternate director.

The December 16 meeting of the society featured a program on "Problems of Current Day Medical Student" by Dr. Evangeline Papageorge, associate dean of Emory University School of Medicine, and an address by Benjamin B. Okel as out-going president of the society. DeKalb County plans to sponsor a vacation travel package to London in March and a 14-day Scandanavian cruise in August.

A Rome landmark, the Dr. Robert Battey 19th century home, was saved recently by a joint effort of the **Floyd-Polk-Chattooga Medical Society,** its auxiliary, city utility companies and police department along with the Rome Area Heritage Foundation. The Auxiliary plans to establish a period medical museum in the restored home and is soliciting appropriate furniture, equipment and instruments.

Thomas R. Freeman was installed as 1975 president of the **Georgia Medical Society** at its annual meeting December 10.

The **Medical Association of Atlanta** held its annual meeting at the Fairmont Colony Square Hotel December 11, electing the following officers: William Logan, president; L. Newton Turk, president-elect; William C. Collins, treasurer; Christopher J. Allan, junior board member; F. William Dowda, senior trustee; Armand E. Hendee, trustee; William B. Spearman, central district trustee; and Joseph S. Wilson, Judicial Council.

College Park pediatrician Ernest A. Dunbar, who has been in practice 22 years, received MAA's 1974 Aven Award for community service. Dr. Dunbar is active with the Boy Scouts, serving as summer camp examining physician eight years; spearheaded the establishment of the mental health wing at Clayton General Hospital and is working with the Department of Human Resources to establish a juvenile mental health center in conjunction with Clayton General Hospital. He also is a charter member of the Clayton County Chamber of Commerce.

FAMILY PHYSICIANS ELECT NEW LEADERSHP

A new slate of officers for the Georgia Academy of Family Physicians was elected at its November annual meeting. James Dismuke began his term as president, Wells Riley of Jonesboro is president-elect and Robert Barr of Cordele is vice president. New members of the Board of Directors include Horace Sawyer of Decatur for the fourth district, Omer Eubanks of Roswell for the fifth, Stephen May of Kennesaw for the seventh, Robert Pumpelly of Jesup for the eighth, and E. W. Holloway of Commerce for the ninth.

For the first time alternate directors were elected and include, by district, 1) J. Roy Rowland of Dublin, 2) Chappell Collins of Albany, 3) Perry Busbee of Cordele, 4) L. L. Freeman of Decatur; 5) John Ellis of Dunwoody, 6) Jesse Sewell of Macon, 7) Donald R. Thomas of Dalton, 8) Fred Gilliard of Douglas, 9) G. H. Perrow of Jasper and 10) George Green of Sparta.

Past president Ollie O. McGahee was selected as a delegate to the American Academy of Family Physicians, with immediate past president Edwin E. Flournoy of Albany as his alternate.

PERSONALS

Fourth District

Floyd R. Sanders, Jr. of Decatur has been reappointed to the DeKalb County Hospital Authority for a four-year term. Dr. Sanders is a past president of the DeKalb County Medical Society and former chief of the medical staff at DeKalb General Hospital.

Fifth District

Wood W. Lovell of Decatur was elected second vice-president of the Southern Medical Association at the organization's 68th annual convention in Atlanta in November.

Stewart E. Wiegand of Atlanta has been elected president of the Atlanta Dermatological Association. Dr. Wiegand, who begins his term in January, was elected at the November meeting of the association.

MAG president **J. Rhodes Haverty** has taken on the added duty as president of the American Society of Allied Health Professions. The installation ceremonies were held during the society's seventh annual meeting in New Orleans in November.

New slate of officers for the Georgia Orthopedic Association is headed by **Grady S. Clinkscales, Jr.** of Atlanta, president, with **Joe Brown** of Brunswick as vice president, **Mercer Bridges** of Augusta as president-elect and **James L. Becton** of Augusta as secretary-treasurer.

Ninth District

Barton McCrum of Gainesville is the new president of the Georgia State Obstetrical and Gynecological Society, Inc. Serving with him will be **Armand Hendee** of Atlanta as secretary-treasurer and **John S. Inman, Jr.**, of Albany, president-elect.

Tenth District

George F. McInnes, Augusta physician, has been appointed director of the Department of Surgery at Wilmington Medical Center in Wilmington, Del. Dr. McInnes has been serving as an assistant clinical professor of surgery at the Medical College of Georgia.

DEATHS

Harold W. Whiteman

Atlanta cardiologist Harold W. Whiteman, 54, died November 15 of cancer.

Dr. Whiteman was chief director of the Board of Directors of Georgia Baptist Hospital. He was awarded a medal for distinguished service and leadership in the advancement of the fight against heart disease in 1971 and 1972 by the Georgia Heart Association. He was instrumental in helping to develop the Berkley Plan which aids the prevention of cardiovascular diseases in school children.

Dr. Whiteman was a graduate of Emory University School of Medicine. During World War II he served in the U.S. Army Air Corps and was a German prisoner three years.

Survivors include his daughters, Sandra Whiteman and Carol Whiteman of Atlanta; sons, Hal Whiteman and Phil Whiteman of Atlanta; mother, Mrs. Thelma Whiteman of Atlanta; and brother, the Rev. Sidney Whiteman of Sunnyside.

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
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DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Menieres Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

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HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

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Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

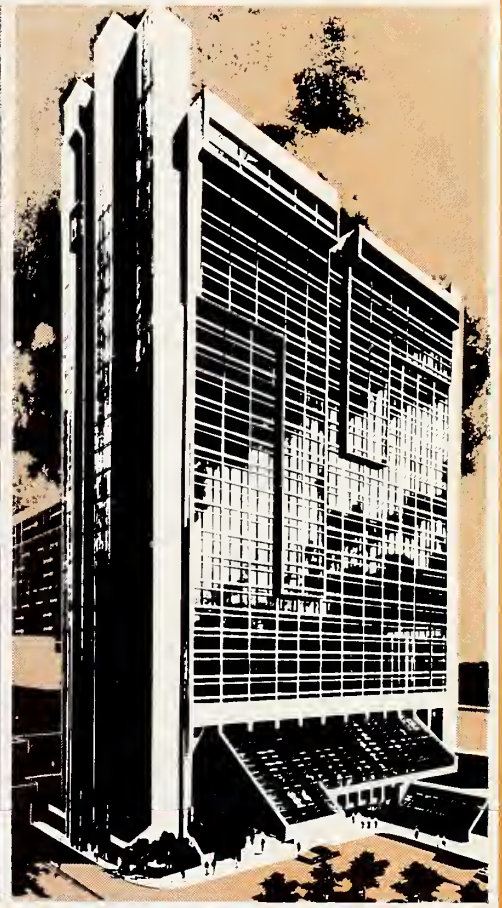
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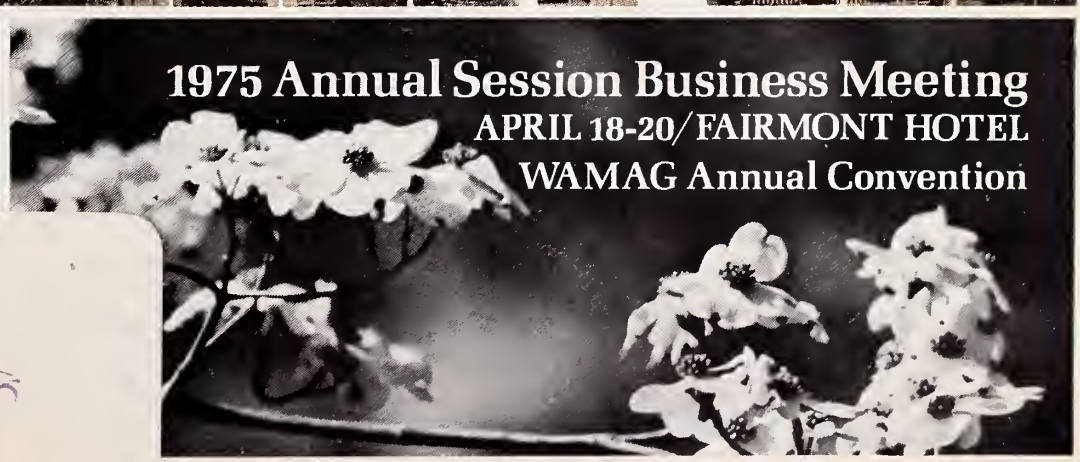








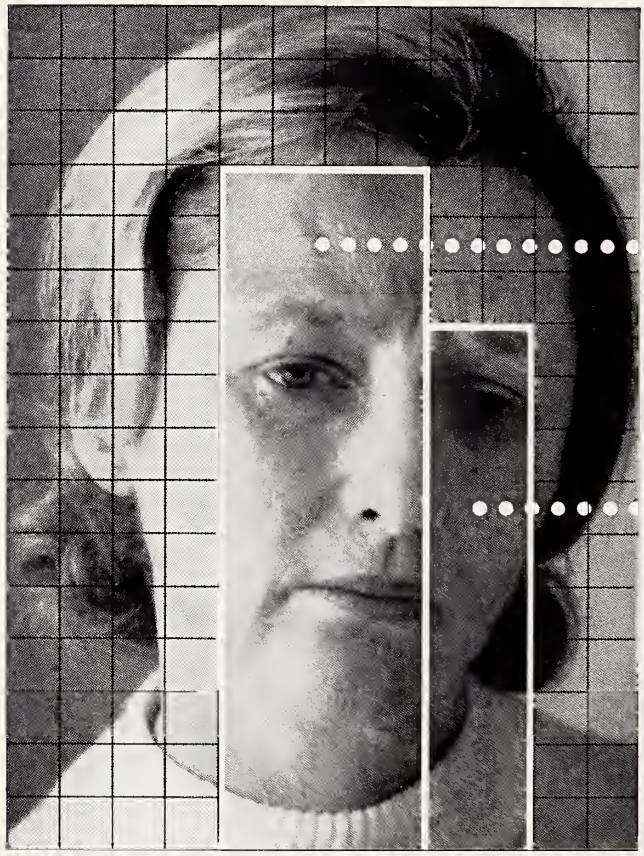




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Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

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OFFICE OF PUBLICATION
The Ovid Bell Press, Inc.
1201-05 Bluff Street
Fulton, Missouri 65251

Second Class postage paid at Fulton, Missouri.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

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Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

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THE COVER

Beautiful Atlanta has much to offer to the conventioner and now ranks third in the nation in the number of meetings hosted, including the 1975 conventions of MAG and its Auxiliary. Atlanta artist Bob Hamill has prepared this montage reflecting the city's character. Photographs courtesy of the Atlanta Historical Society, Fairmont Colony Square Hotel, the Tourist Division of the Georgia Department of Community Development and the Woman's Chamber of Commerce of Atlanta.

PEACHFORD HOSPITAL. A READY REFERENCE.

Peachford is a new, full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*

The hospital has an open medical staff including 37 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30341
Phone 451-7001

Official Call to Annual Session Business Meeting

Extended to all Officers, Councilors, Delegates and Interested Members of the Medical Association of Georgia

The Medical Association of Georgia's Annual Session Business Meeting will be convened in Atlanta, April 18-20, 1975. In May 1973, the House of Delegates approved the division of the Annual Session into the Business and Scientific Meetings and the first Business Session was held in 1974.

This meeting will confine itself to the business affairs of the Association, a memorial service, an awards ceremony, elections of officers and an installation ceremony. There will also be a GaMPAC brunch on Saturday morning, an address by the AMA executive vice president, and the President's reception that evening.

General Sessions

The opening session will be called to order by J. Rhodes Haverty, M.D., Atlanta, president of the Medical Association of Georgia at 9 a.m., on Friday, April 18, 1975, in the Grand Ballroom of the Fairmont Colony Square Hotel. The report of the President of the Woman's Auxiliary to the Medical Association of Georgia and the MAG President-Elect's Address will be the highlights of the morning. The President-Elect of the AMA Auxiliary will also bring greetings.

A combined MAG and Auxiliary Ceremony on Friday, April 18, at 9 a.m. in the Ballroom of the Fairmont Colony Square Hotel will be devoted to the Memorial Service to honor the deceased members of the Medical Association of Georgia and the Woman's Auxiliary to the Medical Association of Georgia.

Saturday morning, April 19, will be highlighted by an address by Dr. James H. Sammons, executive vice president of the AMA, to be followed by an Awards Ceremony at which time AMA-ERF checks will be presented to the two medical schools, 50 Year Membership Certificates, Life Membership Certificates, Certificates of Appreciation, Family Physician of the Year Award, Hardman Award, Civic Endeavor Award and the Distinguished Service Award will be presented. The GaMPAC Brunch will immediately precede this address and the awards presentations.

The Final General Session will be held on Sunday, April 20, in the Ballroom of the Fairmont, immediately following the Second Session of the MAG House of Delegates. At this time there will be the installation of officers, the announcement of sites of the 1975 Scientific and the 1976 Business Session and adjournment.

House of Delegates

The first session of the House of Delegates will convene on Friday, April 18, immediately following the opening General Session, in the Grand Ballroom of the Fairmont. At this time nominations of the MAG officers will be made, and reports of the officers and committees will be heard. The second session of the House of Delegates will be convened on Sunday, April 20 in the same location at 9 a.m. for the hearing of Reference Committee reports. House actions and voting for MAG officers will take place during this second session.

Reference Committees

Members are invited to appear before the Reference Committees of the House of Delegates on any business being considered by the House. The Reference Committees will meet from 1 to 5 p.m. on Friday, April 18, in the assigned rooms at the Fairmont.

Memorial Service

The Association will hold the traditional Memorial Service at the First General Session on Friday, April 18, at 9 a.m. A combined service will be held again this year with the Auxiliary, with the reading of the names of the deceased members of each of the organizations. This ceremony will honor and recall the service and contributions of those deceased members in the past year.

MAG Deceased Members

Claude A. Almand, Lithonia, Oct. 4, 1974
W. C. Baxley, Blakely, June 6, 1974
William G. Brawley, Decatur, May 22, 1974
Samuel Y. Brown, Atlanta, Oct. 4, 1974
James R. Bryan, Augusta, Dec. 12, 1974
B. Russell Burke, Atlanta, Sept. 18, 1974
C. Walter Coolidge, Atlanta, Dec. 28, 1974
J. J. Collins, Thomasville, Dec. 28, 1974

John M. Dent, Jr., Tifton, Oct. 4, 1974
George P. Dillard, Atlanta, Oct. 25, 1974
Herbert M. Edge, Blairsville, May 31, 1974
W. G. Elliott, Cuthbert, May 12, 1974
Charles H. Field, Macon, May 11, 1974
H. E. Griggs, Conyers, April 22, 1974
Lawton Quinby Hair, Augusta, Dec. 14, 1974
Earl W. Hathcock, Atlanta, July 31, 1974
Ralph N. Johnson, Rome, Jan. 20, 1972
Charles S. Jones, Atlanta, June 7, 1974
E. C. Jungck, Augusta, July 17, 1974
Lewell S. King, College Park, Aug. 19, 1974
J. H. Lamm, Macon, June 23, 1974
Frederic R. Minnich, Atlanta, May 19, 1974
F. W. Morgan, Douglasville, June 15, 1973
Hugh G. Mosley, Atlanta, Jan. 29, 1975
Jack C. Norris, Atlanta, June 22, 1974
William W. Puett, Norcross, Jan. 12, 1975
W. B. Quillian, Jr., Cartersville, Jan. 28, 1975
David E. Quinn, Dublin, Sept. 29, 1974
Charles Shorter, Atlanta, June 7, 1974
John E. Smith, Fitzgerald, Jan. 12, 1975
J. K. Stalvey, Jr., Savannah, June 14, 1974
Bernard Strickman, Atlanta, Feb. 5, 1975
Hart Sylvester, Hawkinsville, April 28, 1974
Harold Whiteman, Atlanta, Nov. 15, 1974
Edward S. Wright, Atlanta, Sept. 6, 1974
Francis M. Ziegler, Albany, Nov. 2, 1974

Auxiliary Deceased Members

Mrs. Joseph M. Almand, Jr. ..... La Grange
Mrs. Warren G. Coleman ..... Eastman
(Past State President)
Mrs. C. B. Elliot ..... Cuthbert
Mrs. John C. Mitchell ..... Augusta
Mrs. W. T. Smith ..... Tifton
Mrs. Henry E. Steadman ..... Atlanta

Awards

Physicians to be awarded Life Membership Cards and 50 Year Membership Certificates will be honored at the Awards Ceremony on Saturday, April 19, at noon in the Fairmont Colony Square Hotel Ballroom:

Life Members

Oliver Arteaga ..... Atlanta
H. J. Bickerstaff ..... Columbus
W. C. Boswell ..... Thomasville
Leslie Buckner ..... Leesburg
Don Cathcart ..... Atlanta
Grady N. Coker ..... Canton
Murphy K. Cureton ..... LaFayette
John I. Hall ..... Macon
Alton V. Hallum, Sr. ..... Atlanta
James P. Hanner ..... Atlanta
G. H. Johnson, Jr. ..... Savannah
S. B. Kitchens ..... LaFayette
Lawrence P. Matthews ..... Atlanta
J. R. S. Mays ..... Macon
Charles E. McArthur ..... Cordele
Willis T. McCurdy ..... Stone Mountain
W. A. Mendenhall ..... Decatur
Charles Rieser ..... Atlanta
Samuel F. Rosen ..... Savannah Beach
W. Pat Smith ..... Decatur
John L. Stapleton ..... Columbus

50 Year Members

Evert A. Bancker ..... Atlanta
Clark H. Bryant ..... Comer
Verlin L. Bryant ..... Wadley
Daniel L. Burns ..... Valdosta
John Bush ..... Columbus
John R. Evans ..... Stone Mountain
Major F. Fowler ..... Atlanta
Thomas B. Gay ..... Atlanta
William A. Kelley ..... Atlanta
Ruskin King ..... Savannah
Harold P. McDonald ..... Atlanta
Hugh G. Mosley (deceased) ..... Atlanta
Carl P. Savage ..... Montezuma
Bruce Threatte ..... Columbus
Richard B. Weeks ..... St. Simon's Island
R. Hugh Wood ..... Atlanta

The following awards will also be made at the General Session on April 19: AMA-ERF checks to the two medical schools, Certificates of Appreciation, Family Physician of the Year, the Hardman Award, the Civic Endeavor Award and the Distinguished Service Award.

President's Reception

The Association will honor its President at a Reception to be held at 6:30 p.m., Saturday, April 19, in the Ballroom of the Fairmont.

GaMPAC Brunch

The Georgia Medical Political Action Committee will hold a brunch for all MAG and Auxiliary members in the Ballroom on Saturday, April 19, from 9:30 a.m. to 11 a.m.

Alumni Events

The alumni receptions and dinners of the two Georgia medical schools, as well as other medical alumni class reunions are held, if desired, during this Business Meeting.

Registration

A general registration desk for all will be open in

the Ballroom Foyer of the Fairmont Hotel on Friday, April 18, from 7:30 a.m. to 5 p.m.; on Saturday, April 19, from 7:30 a.m. to 5 p.m.; and on Sunday, April 20, the registration desk will be open from 7 a.m. (for distribution of Reference Committee Reports) to noon. Admission to meetings will be by registration badge only.

Council

The MAG Executive Committee of Council will meet at 10 a.m., Thursday, April 17, in the Squire Room of the Fairmont Hotel and the Council meeting is scheduled for 2 p.m. in the same room. There will also be an organizational meeting of Council immediately following the adjournment of the Annual Session on Sunday, April 20, in the Ballroom.

Hotel Reservations

Officers, councilors, and delegates will be housed in a reserved block of rooms at the Fairmont Hotel. Special reservation forms have been issued to the above by the MAG Headquarters Office. Please mail your room reservation request directly to the hotel.

MAG Message Center

A message center will be maintained near the MAG Official Registration Desk for the convenience of the membership. Pages from the Auxiliary to the Medical Association of Georgia will staff this message center during the entire Session for incoming messages only.

A bulletin board at this center will be available for notices of special importance and messages will be delivered to the Ballroom during the General Sessions and the House of Delegates meetings.

MAG Headquarters Office

The Association staff will maintain a Headquarters Office in the State Room of the Fairmont Hotel on the Ballroom level near the Registration Desk.

Scientific Meeting

A separate scientific meeting, being planned with the cooperation of the Interspecialty Council and specialty societies, is scheduled for November 1975 in Atlanta. The MAG House of Delegates voted in 1973 to separate the scientific and business portions of its program. See the February editorial and President's Letter for additional information.

Leisure

In order for the membership to have some time during the Business Meeting to enjoy their own interests Saturday afternoon, April 19, is open for whatever the members may desire.

PROMPT COMPLETION OF DEATH CERTIFICATES IS THE LAW, ALLEY CAUTIONS

James W. Alley, M.D., director of the Division of Physical Health, Georgia Department of Human Resources, has some words of caution for physicians that pertain to completion of death certificates.

"The Georgia Health Code is explicit in its provisions for the completion and filing of death certificates," Dr. Alley points out, "but it is not being adhered to in all cases. Serious problems are arising in some areas."

He urges physicians not thoroughly familiar with these legal demands to review Chapter 88-1715 of the Georgia Health Code for their own protection.

The health director explains that the law requires that a death certificate shall be filed with the registrar of the district in which the death occurred or the body was found within 72 hours after such death and prior to final disposition or removal of the body from the state.

It provides that if the place of death is unknown, a death certificate shall be filed in the registration district in which the dead body is found within 72 hours after occurrence. If death occurs in a moving conveyance, a death certificate shall be filed in the registration district in which the body was first removed from such conveyance and pronounced dead by a qualified physician or coroner.

Funeral directors have responsibility for obtaining personal data, preparing certificates, securing signatures required by the certificates and filing with registrars. It is their duty to obtain medical certification of the cause of death in addition to personal data.

The medical certification portion of the death certificate must, by law, be completed and signed within 48 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death, except when inquiry is required by the Post Mortem Examinations Act (Chapter 21-2).

The Code further stipulates that when death occurred without medical attendance or when inquiry is required by the Post Mortem Examinations Act, the proper person (the coroner) shall investigate the cause of death and shall complete and sign the medical certification portion of the death certificate within a reasonable time after being notified of death.

"Delays in completing medical certification portions of death certificates are occurring," says Dr. Alley. "Physicians need to be aware of their legal responsibility for prompt handling of these vital records to avoid any unpleasant repercussions over failure to comply with the law," he adds.

1974-1975 MAG Officers and Council

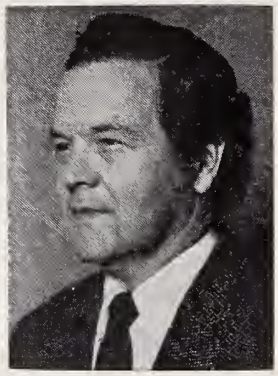
Officers

President
J. Rhodes Haverty, Atlanta (1975)*
President-Elect
David A. Wells, Dalton (1975)*
Immediate Past President
C. E. Bohler, Brooklet (1977)*
Past Presidents
F. W. Dowda, Atlanta (1976)
W. C. Mitchell, Smyrna (1975)
First Vice President
Luther M. Thomas, Jr., Augusta (1975)*
Second Vice President
W. Daniel Jordan, Atlanta (1975)*
Chairman of Council
Fleming L. Jolley, Atlanta (1975)*
Secretary
Earnest C. Atkins, Atlanta (1975)*
Treasurer
Carson B. Burgstiner, Savannah (1975)*
Speaker of the House
L. C. Buchanan, Decatur (1977)*
Vice Speaker of the House
Ronald F. Galloway, Augusta (1977)*
Chairman of Finance Committee
F. G. Eldridge, Valdosta (1975)*
Editor *JMAG*
Edgar Woody, Jr., Atlanta (1975)

Councilors

District:
1—Albert M. Deal, Statesboro (1976)
2—J. Dan Bateman, Albany (1976)
3—John H. Robinson, Americus (1976)
6—James M. Skinner, Griffin (1977)
7—Don Schmidt, Cedartown (1977)
8—Robert E. Perry, Jr., Brunswick (1977)
9—Paul T. Scoggins, Commerce (1975)
10—Edwin W. Allen, Jr., Milledgeville (1975)
Bibb County Medical Society
Milton I. Johnson, Macon (1975)
Cobb County Medical Society
Remer Y. Clark, Marietta (1975)
DeKalb County Medical Society
Luther M. Vinton, Avondale Estates (1975)
Medical Association of Atlanta
John T. Godwin, Atlanta (1977)
Fleming L. Jolley, Atlanta (1975)
J. Harold Harrison, Atlanta (1976)
Georgia Medical Society
L. R. Lanier, Jr., Savannah (1976)

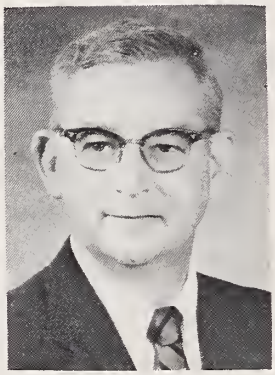
* Executive Committee.



J. Rhodes Haverty
President



David A. Wells
President-Elect



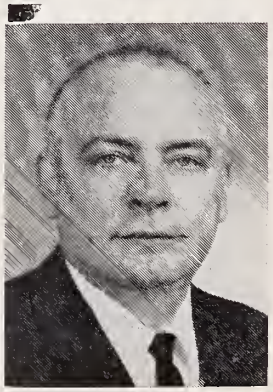
Fleming L. Jolley
Chairman of Council



Luther M. Thomas, Jr.
First Vice President



W. Daniel Jordan
Second Vice President



Earnest C. Atkins
Secretary



Carson B. Burgstiner
Treasurer

Muscogee County Medical Society
Jack A. Raines, Columbus (1977)
Richmond County Medical Society
Ronald F. Galloway, Augusta (1975)

Vice Councilors

District:
1—Leon E. Curry, Metter (1976)
2—Frank R. Miller, Thomasville (1976)
3—B. Lamar Pilcher, Warner Robins (1976)
6—Norman P. Gardner, Thomaston (1977)
7—Richard A. Griffin, Cartersville (1977)
8—Joe C. Stubbs, Valdosta (1977)
9—Robert S. Tether, Gainesville (1975)
10—M. A. Hubert, Athens (1975)
Bibb County Medical Society
Beverly B. Sanders, Macon (1975)
Cobb County Medical Society
Charles R. Underwood, Marietta (1975)
DeKalb County Medical Society
Stanley P. Aldridge, Decatur (1975)
Medical Association of Atlanta
J. Norman Berry, Sandy Springs (1977)
T. J. Anderson, Jr., Atlanta (1975)
W. W. Moore, Jr., Atlanta (1976)
Georgia Medical Society
Irving Victor, Savannah (1976)
Muscogee County Medical Society
Louis A. Hazouri, Columbus (1977)
Richmond County Medical Society
Henry D. Scoggins, Augusta (1975)

AMA Delegates

Delegates	*Term Ending*
J. W. Chambers, LaGrange	12-31-75
John S. Atwater, Atlanta	12-31-75
Harrison L. Rogers, Atlanta	12-31-76
J. Dan Bateman, Albany	12-31-76

Alternate Delegates	*Term Ending*
F. G. Eldridge, Valdosta	12-31-75
Luther M. Vinton, Avondale Estates	12-31-75
C. E. Bohler, Brooklet	12-31-76
F. W. Dowda, Atlanta	12-31-76

Official Program

Friday, April 18

7:30 GENERAL AND DELEGATES REGISTRATION
Ballroom Foyer, Fairmont Hotel

9:00 FIRST GENERAL SESSION
Grand Ballroom
Presiding: J. Rhodes Haverty, M.D., Atlanta, President, Medical Association of Georgia

Call to Order

Invocation

Memorial Service

Introduction of Distinguished Guests

Report of President of Woman's Auxiliary: Mrs. George I. Harrison, Marietta

Greetings from the President-Elect of the Woman's Auxiliary to the American Medical Association: Mrs. Erle E. Wilkinson, Nashville, Tennessee

President-Elect's Address: David A. Wells, M.D., Dalton

Announcements

Recess

10:00 FIRST SESSION, HOUSE OF DELEGATES
Grand Ballroom
Presiding: L. C. Buchanan, M.D., Decatur, Speaker

Nominations of officers of MAG, AMA delegates and alternate delegates and report of councilor elections

Introduction of Business

Announcements

Recess

1:00 REFERENCE COMMITTEE MEETINGS
Fairmont Hotel

6:30 and 8:00 ALUMNI RECEPTIONS AND DINNERS
(If Requested)

Saturday, April 19

7:30 GENERAL DELEGATES REGISTRATION
Ballroom Foyer

9:30 to 11:00 GAMPAC BRUNCH
Grand Ballroom
(All physicians, auxiliary members and

guests invited)
Presiding: J. Daniel Bateman, M.D., Albany, Chairman

11:30 to 12:30 GENERAL SESSION
Grand Ballroom
Presiding: J. Rhodes Haverty, M.D., Atlanta, President, Medical Association of Georgia

Address: James H. Sammons, M.D., Executive Vice President, American Medical Association, Chicago

Presentation of Awards:
AMA-ERF Checks—J. Rhodes Haverty, M.D.
Fifty Year Membership Certificates—Luther Thomas, M.D.
Life Membership Certificates—W. Dan Jordan, M.D.
Certificates of Appreciation—Earnest C. Atkins, M.D.
Family Physician of the Year Award—James C. Dismuke, M.D.
Hardman Award—J. Rhodes Haverty, M.D.
Civic Endeavor Award—J. Rhodes Haverty, M.D.
Distinguished Service Award—J. Rhodes Haverty, M.D.

6:30 to 7:30 PRESIDENT'S RECEPTION
Grand Ballroom
(All members, their wives and guests invited)

Sunday, April 20

7:00 GENERAL AND DELEGATES REGISTRATION
Ballroom Foyer

9:00 SECOND SESSION, HOUSE OF DELEGATES
Grand Ballroom
Presiding: L. C. Buchanan, M.D., Decatur, Speaker

Election of MAG officers, AMA delegates and alternate delegates

Reference Committee Reports

Announcements

Adjournment of House of Delegates

12:00 FINAL GENERAL SESSION
Grand Ballroom
(All physicians, auxiliary members and guests invited)
Presiding: J. Rhodes Haverty, M.D., Atlanta, President, Medical Association of Georgia

Installation of Officers

Announcements of site of 1975 Scientific Session and 1976 Business Session

Adjournment of 121st Annual Session

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor. If given, this award will be presented on Saturday, April 19 at noon. By custom this award usually has gone to a Georgia physician. However, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at the MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Saturday, April 19 at noon.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at the MAG Headquarters office at least two weeks in advance of the Annual Session. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Saturday, April 19 at noon.

Certificates of Appreciation

Recipients of Certificates of Appreciation will be selected jointly by the MAG Committee on Awards, Executive Committee and Council. These will be presented on Saturday, April 19 at noon.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the Annual Session. The name of the family physician, accompanied by supporting biographical data was to be received at MAG Headquarters by January 15. The President of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Saturday, April 19 at noon.

NEW HEART ASSOCIATION EDUCATION PROGRAM INVOLVES THE PHYSICIAN-PUPIL IN THE TEACHING PROCESS

Since its founding in 1948, the Georgia Heart Association has been concerned with research, patient services, and education. The education programs have been directed toward both the health care professionals and the public. Traditionally, these programs for physicians and nurses have been lectures and panels, many given by experts from outside the state. They have been presented at the annual session in September and at meetings such as the Atlanta Graduate Medical Assembly.

During the past few years, many physicians concerned with continuing medical education have concluded that while lectures and panels are useful, they are not the best way to help physicians improve their practice habits. A better way appears to be the involvement of the physician-pupil in the teaching process itself, by using his patients as subjects for discussion. This usually requires the teacher to go to the local hospital (or office) of the practitioner and to point out solutions that are practical in that setting.

At a Unicoi Conference in 1974, the Physician Education Committee of the Georgia Heart Association, chaired by Donald Nutter, M.D. of Atlanta (Emory), decided to start an educational program of this type. Frank L. Ferrier, M.D. of Atlanta and Marietta was asked to direct the project. He first contacted a number of hospitals in Georgia to determine their needs. Soon realizing the enormousness of the task, he decided to set up a pilot program that could be expanded after some of the early problems had been solved.

Robert Wight, M.D. of Tifton, made the local arrangements for the first program which was held at Tift General Hospital December 12, 1974. Mark Silverman, M.D. of Atlanta (Emory), the visiting teacher, talked about common arrhythmias seen in out-patients and in coronary care units. This was followed by an audience participation discussion of an algorithm for the treatment of arrhythmias. Twenty-six physicians from a number of surrounding towns attended the conference; many participated in the discussion. It was a successful meeting.

The Education Committee of the Medical Association of Georgia has been directing its continuing medical education efforts toward promoting local education programs. Because of this, Nicholas Davies, M.D. of Atlanta, chairman of the committee, and Stephen Daniel, Ph.D., assistant executive director, education for MAG, joined Dr. Silverman and Dr. Ferrier to observe the first program in Tifton. The Medical Association is encouraging community hospitals to start new educational programs or to upgrade their old ones. Programs of high quality can be accredited by MAG and the American Medical Association. The Medical Association is also beginning to encourage voluntary health agencies (Heart, Cancer, Lung, Diabetes, etc.) to provide educational resources for community hospitals. The Association especially encourages community hospitals to seek help from the two medical schools in planning their educational programs.

The Georgia Heart Association will carry out other community hospital education projects during 1975. Tift General Hospital will have quarterly programs sponsored again by the Heart Association. Other communities to be involved with this program are Brunswick with Wade Strickland, M.D. as sponsor, and Rome with Ray Young, M.D. sponsoring.

Further information about these projects may be obtained from Dr. Frank L. Ferrier at the Georgia Heart Association, Broadview Plaza, Level C., 2581 Piedmont Road, N.E., Atlanta, Ga. 30324, or Dr. Stephen Daniel at the Medical Association of Georgia, Atlanta.

WAMAG 50th Annual Convention

April 17-20, 1975 · Fairmont Colony Square Hotel · Atlanta

President's Greeting



IT IS MY PLEASURE to welcome you to the 50th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia. Convention is a time to summarize our year's activities and share the experiences and the knowledge we have gained.

This year we are privileged to meet in Atlanta and have as our hostess the Woman's Auxiliary to the Medical Association of Atlanta assisted by the Clayton-Fayette, Cobb and DeKalb Auxiliaries.

I sincerely hope that you will join us for our business sessions and participate in the exciting activities that are being planned for the convention.

Mrs. George I. Harrison, *President*
Woman's Auxiliary to the
Medical Association of Georgia

Welcome to Atlanta



WE THE MEMBERS of the Woman's Auxiliary to the Medical Association of Atlanta are eagerly awaiting your arrival and are busy getting out the "red carpet" for the 50th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

We are grateful for the opportunity each year at Annual Convention to enjoy the fellowship and exchange of ideas with our sister auxiliaries and are honored that, this year, you have chosen to come to Atlanta.

Catherine White, our convention chairman, par excellence, has made some wonderful plans—and we and members of DeKalb and Cobb County Auxiliaries will be ready and waiting to greet you with four days of fun and relaxation!

It's a real pleasure to welcome you. See you in April in Atlanta!

Mrs. John K. Davidson, III, *President*
Woman's Auxiliary to the Medical
Association of Atlanta

The Program

(All events in Fairmont Colony Square Hotel unless otherwise indicated.)

Thursday, April 17

2:00 to 5:00 **REGISTRATION AND INFORMATION**
Assembly Room

4:00 to 5:30 **PRE-CONVENTION EXECUTIVE BOARD MEETING**
Georgia Room
Presiding: Mrs. George I. Harrison, Marietta, President, Woman's Auxiliary to the Medical Association of Georgia

Invocation: Mrs. Russell E. Andrews, Jr., Rome, Third Vice President

Pledge of Loyalty and Collect: Mrs. Mikell B. Karsten, Tifton, President, Tift County Medical Society Auxiliary

Introduction of Past Presidents: Mrs. Cliff Moore, Jr., Rome, Past President

Adjournment

5:30 to 6:30 **RECEPTION**
Auxiliary President's Suite
(For 1974-75 and 1975-76 Executive Board

and county presidents-elect)
Presiding: Mrs. Phil C. Astin, Jr., Carrollton, President-Elect

7:30 EVENING OUT
(Arrangements to be announced)

Friday, April 18

8:30 to 5:00 REGISTRATION AND INFORMATION
Assembly Room

8:30 to 5:00 HOSPITALITY AND COUNTY EXHIBITS
Assembly Room

9:00 to 12:00 MAG FIRST GENERAL SESSION, MAG AND AUXILIARY MEMORIAL SERVICE AND HOUSE OF DELEGATES
Grand Ballroom
(All MAG and auxiliary members and guests invited)
Presiding: J. Rhodes Haverty, M.D., Atlanta, President, Medical Association of Georgia

Memorial Service

Report of Woman's Auxiliary to the Medical Association of Georgia: Mrs. George I. Harrison, Marietta, President

Greetings from the Woman's Auxiliary to the American Medical Association: Mrs. Erle E. Wilkinson, Nashville, Tennessee, President-Elect

11:00 to 12:00 AUXILIARY GENERAL MEETING
Haversham Room
Call to Order: Mrs. George I. Harrison, Marietta, President

Invocation: Mrs. Milton F. Bryant, Atlanta

Pledge of Allegiance to Flag: Mrs. Milledge C. Newton, Macon, President, Bibb County Medical Auxiliary

Pledge of Loyalty and Collect: Mrs. Clarence E. Bridger, Albany, President, Dougherty County Medical Auxiliary

Address of Welcome: Mrs. John K. Davidson, III, Atlanta, President, Woman's Auxiliary to the Medical Association of Atlanta

Response to Welcome: Mrs. Richard W. Egan, Jekyll Island, President, Glynn County Medical Auxiliary

Presentation of Convention Plans: Mrs. Perry M. White, Atlanta

Introduction of Pages for the Day: Mrs. Roy W. Vandiver, Stone Mountain, President, DeKalb County Medical Auxiliary

Introduction of Past Presidents and Guests: Mrs. Hayward S. Phillips, Lilburn, Past President

Greetings: President of MAG, J. Rhodes Haverty, M.D., Atlanta; and President-Elect of MAG, David A. Wells, M.D., Dalton

Introduction of Guest Speaker: Mrs. Louie Griffin, Claxton, Past President, and Past President of Southern Medical Auxiliary

Address: Mrs. James H. Manning, Marietta, President, Woman's Auxiliary to the Southern Medical Association

Introduction of County Presidents: Mrs. Phil C. Astin, Carrollton, President-Elect

Idea Exchange: County Presidents
(All reports limited to two minutes)

Business Session
(All reports limited to two minutes)

Convention Rules of Order: Mrs. Peter C. Sotus, Atlanta, Parliamentarian

Roll Call and Minutes: Mrs. D. Morton Boyette, Albany, Recording Secretary

Treasurer's Report (Including Auditor's Report): Mrs. Murphy K. Cureton, LaFayette, Treasurer

Report of Advisory Committee to the WAMAG: James H. Manning, M.D., Marietta

President's Report: Mrs. George I. Harrison, Marietta

President-Elect's Report: Mrs. Phil C. Astin, Carrollton

Addendum Reports—State Officers and Chairmen (Complete reports are published in the 1974-75 Annual Report)

Recommendations from the Executive Board: Mrs. D. Morton Boyette, Albany, Recording Secretary

Report of Revisions Committee: Mrs. George W. Statham, Decatur, Chairman

Report of the Budget and Finance Committee: Mrs. Prentiss Parker, Marietta, Chairman

Report of the Resolutions Committee: Mrs. Harry B. O'Rear, Augusta, Chairman and Middle Georgia Area Vice-President

Report of the Credentials Committee: Mrs. David L. Morgan, Decatur

Announcements

12:00 RECESS OF SESSION

12:30 BUSES LEAVE FOR LUNCH

1:00 to 4:30 LUNCHEON AND TOUR
(Location to be announced)
Honoring: Mrs. Erle E. Wilkinson, President-Elect, Woman's Auxiliary to the American Medical Association
Presiding: Mrs. George I. Harrison, Marietta

Invocation: Mrs. Peter C. Sotus, Atlanta, Parliamentarian

Introduction of Past Presidents and Guests: Mrs. Shelley C. Davis, Atlanta, Past President

Introduction of Guest Speaker: Mrs. George W. Statham, Decatur, Past President

Address: Mrs. Erle E. Wilkinson, Nashville, Tennessee, President-Elect, Woman's Auxiliary to the American Medical Association

7:30 EVENING OUT
(Arrangements to be announced)

Saturday, April 19

8:30 PAST PRESIDENTS' BREAKFAST (DUTCH)
Izmir Room
Presiding: Mrs. John G. Bates, Past President

HOTEL RESERVATIONS AT FAIRMONT COLONY SQUARE

For those Auxiliary members who are *not* on the Auxiliary Executive Board, and who desire to stay at the Fairmont, please write MAG Headquarters, 938 Peachtree Street, N.E., Atlanta, Georgia 30309, Attention: Mrs. Catherine Wooten, for a reservation card.

Auxiliary members whose husbands are MAG delegates, officers or councilors will receive a special hotel reservation card which will entitle them to stay at the Fairmont. The Auxiliary Executive Board members have been mailed a hotel card also.

None of the metropolitan Atlanta area members are expected to stay in the hotel as the Fairmont would reserve only 400 rooms for MAG and Auxiliary use.

8:30 to 5:00 REGISTRATION AND INFORMATION
Assembly Room

8:30 to 5:00 HOSPITALITY AND COUNTY EXHIBITS
Assembly Room

9:30 to 11:00 GaMPAC BRUNCH
Ballroom

11:30 to 12:30 MAG GENERAL SESSION
Grand Ballroom
Presiding: J. Rhodes Haverty, M.D., Atlanta, President, Medical Association of Georgia

Address: James H. Sammons, M.D., Executive Vice President, American Medical Association, Chicago

11:00 to 12:30 SECOND GENERAL SESSION
Habersham Room
Call to Order: Mrs. George I. Harrison, Marietta, President

Introduction of Pages: Mrs. Roy W. Vandiver, Stone Mountain, Chairman

Report of Awards Committees
Achievement Awards: Mrs. Jack F. Menendez, Macon, Chairman
AMA-ERF Awards: Mrs. Michael A. Glucksman, Brunswick, Chairman, and Mrs. Ralph A. Tillman, Decatur, Co-Chairman
Marie S. Burns Safety Award: Mrs. George M. Calloway, Jr., Atlanta, Chairman
Mrs. James Bonner White Scrapbook Awards: Mrs. Charles M. Ward, Dawson, Chairman

James N. Brawner, Sr., M.D. Awards for Excellence: Mrs. John G. Bates, Cuthbert, Chairman
(Winners of Awards will please remain after adjournment for official photographs.)

Report of Nominating Committee: Mrs. John G. Bates, Cuthbert, Chairman

Election of Officers

Installation of Officers: Mrs. Erle E. Wilkinson, Nashville, Tennessee, President-Elect, Woman's Auxiliary to the American Medical Association

Inaugural Address and Announcements of 1974-75 State Chairmen: Mrs. Phil C. Astin, Carrollton, President

Presentation of Past President's Pin: Mrs. John G. Bates, Cuthbert, Past President

Report of Credentials Committee: Mrs. David L. Morgan, Decatur, Chairman

Announcements

Adjournment

1:00 to 3:00 LUNCHEON AND FASHION SHOW
Venetian Room
Honoring: Awards Recipients
Presiding: Mrs. George I. Harrison, Marietta, President

Invocation: Mrs. Robert M. Fine, Decatur, Area Vice President

Introduction of Past Presidents and Guests: Mrs. E. W. Waldemayer, Past President

Featuring fashions by Mrs. Marvin Johnson, Augusta

3:30 to 5:00 POST-CONVENTION EXECUTIVE BOARD MEETING
Georgia Room
Presiding: Mrs. Phil C. Astin, Carrollton, President

6:30 to 7:30 MAG PRESIDENT'S RECEPTION
Grand Ballroom

Sunday, April 20

9:00 to 12:00 MAG SECOND SESSION HOUSE OF DELEGATES, ELECTIONS AND INSTALLATION OF OFFICERS
Grand Ballroom
(All Auxiliary members and guests invited)

Convention Committees

General Chairman
Mrs. Perry M. White, Atlanta
Vice-Chairman
Mrs. Thomas Marks, Atlanta
Registration and Credentials
Mrs. David L. Morgan, Decatur
Tellers
Mrs. Hayward Phillips, Lilburn
Ticket
Mrs. J. Hagen Baskin, Atlanta
Timekeepers
Mrs. Alex E. Robertson, Augusta
Mrs. David C. Thibodeaux, Marietta
Resolutions Committee
Mrs. Harry B. O'Rear, Augusta
Mrs. George G. Haberman, Savannah
Reading Committee
Mrs. E. K. McLain, Augusta
Mrs. Clem Doxey, Marietta
Mrs. Hamilton Dixon, Rome
Courtesy Committee
Mrs. William Collins, Atlanta
Arts and Crafts
Mrs. W. Scott James, Atlanta
County Exhibits
Mrs. Ralph A. Tillman, Lawrenceville
Hospitality Committee
Mrs. Ralph R. Tillman, Lawrenceville
Pages
Mrs. Roy W. Vandiver, Stone Mountain
Publicity
Mrs. George M. Callaway, Jr., Atlanta
Arrangements
Mrs. Ellis Keener, Atlanta
Reception for 74-75 and 75-76 Board
Mrs. George M. Callaway, Jr., Atlanta
Past President's Breakfast
Mrs. Howard S. Brown, Dunwoody
Saturday Luncheon
Mrs. George W. Statham, Decatur
Fashion Show
Mrs. Marvin Johnson, Augusta
Mrs. J. Hagen Baskin, Atlanta
Evenings Out Dinner
Mrs. Shelley Davis, Atlanta



While in Atlanta . . .

Atlanta Zoo and Cyclorama: Located in Grant Park, the zoo is the largest in the state and contains a petting zoo for children as well as one of the best reptile collections in the country. Open daily 10 a.m. to 5:30 p.m. Cyclorama is a three-dimensional panorama of the Battle of Atlanta in 1864. Open daily, lectures on the half-hour.

Capitol Building: Gold-domed building housing the state legislature, Georgia State Museum of Science and Industry and Hall of Fame. Open daily.

Fernbank Science Center: 156 Heaton Park Drive, N.E. near Emory University. Educational facility housing the third-largest planetarium in the nation, an observatory, museum, exhibit hall and forest. Open daily.

Governor's Mansion: 391 West Paces Ferry Road, N.W. Greek revival style mansion in fashionable residential district. Scheduled to be open again for public tours in April from 3 to 5 p.m. on Sundays.

Lion Country Safari: 20 miles south of Atlanta on I-75 at Highway 138. Wild animal preserve in which you can drive among free-roaming animals. Also offers rides, shows, displays and shops in addition to the Sky-High Safari Tower. Open daily.

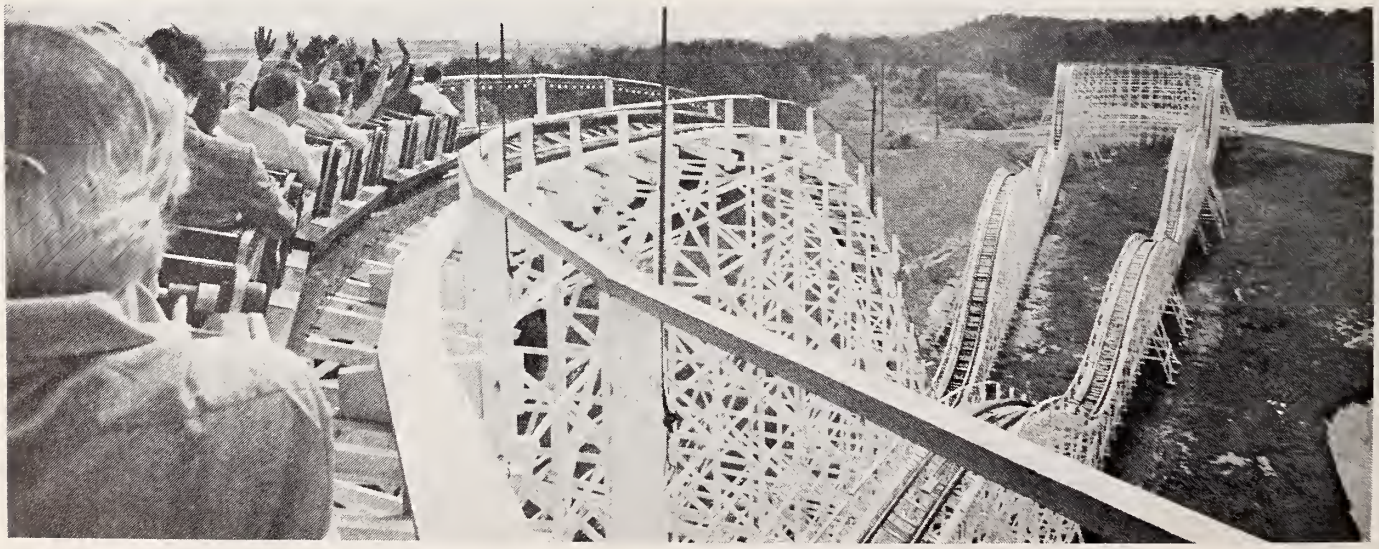
Memorial Arts Center: 1280 Peachtree St., N.E., just steps away from the headquarters hotel. Home of the Atlanta Symphony, High Museum of Art, Children's Theater, Atlanta School of Art and Alliance Theater. Open daily.

Six Flags Over Georgia: I-20 West, 10 minutes from Atlanta. A 376-acre theme park with one admission price for over 75 rides, shows and attractions. Open weekends in April from 10 a.m. to 10 p.m.

Stone Mountain: Take I-285 east and exit at the Stone Mountain-Athens turnoff. Attractions at the 3,200-acre park include the largest stone sculpture in the world, restored antebellum plantation, water sports and steamboat ride, skylift, scenic railroad, antique auto and music museum, game ranch and golf course. Open daily.

Swan House: 3099 Andrews Dr., not far from the Governor's Mansion. Headquarters for the Atlanta Historical Society in an elegant 1928 mansion open for tours daily. Adjacent coach house offers a restaurant, art gallery and gift shop. Also on the grounds is the Tullie Smith House Restoration, built in the 1840's, depicting the lifestyle of the period with its house, detached kitchen and log outbuildings such as the barn and slave cabin.

Underground Atlanta: Alabama Street, S.W., near the Capitol. A "city beneath the city" with 100 shops, restaurants, saloons and boutiques in a Gay 90's setting.



Recommended Restaurants

The Abbey
669 West Peachtree St., N.E./881-8127. Country French cuisine in a converted monastery. Open daily, except Sunday, 6 p.m. until 11 p.m.; lounge open 4:30 p.m. to 2 a.m.

Anthony's
3109 Piedmont Road, N.E./233-7129. Authentic plantation built in 1797 featuring French cuisine and seafood. Open for dinner 5:30 to 10:30 p.m.

The Bonnie Brooks Farm Restaurant
3820 Roswell Road, N.E./237-7504. Wrought iron, old brick and antique stained glass windows give warmth to this Georgia farm house with European and American cuisine. Open 6 p.m. to midnight Friday and Saturday.

Brennan's
103 West Paces Ferry Road, N.W./261-7913. Offers the same delicious food as the original Brennan's in New Orleans. Breakfast daily from 9 a.m. to 3 p.m.; luncheon weekdays from 11:30 a.m. to 3 p.m.; dinner from 6 p.m.

Clock of Fives
265 Peachtree St., N.E./577-1234. Giant copper chandeliers and stained oak tables plus hearty, good food are reminiscent of an English inn. Located in the Hyatt Regency Hotel and open daily.

590 West
Stouffer's Atlanta Inn, 590 W. Peachtree St., N.E./881-6000. Continental cuisine and a breathtaking view of Atlanta. Open Monday through Saturday for luncheon, dinner and cocktails.

Gene & Gabe's Restaurant
1578 Piedmont Road/876-9426. Popular spot featuring Italian food. Open 6 p.m. to midnight.

Hugo's
265 Peachtree St., N.E./577-1234. Continental gourmet cuisine at the Hyatt Regency Atlanta Hotel. One of the city's most elegant restaurants. Open for dinner each evening; for lunch weekdays.

Joe Dale's Cajun House
3209 Maple Drive, N.E./261-2741. Cajun, New Orleans style dishes served from 5:30 to 11 p.m. daily except Sunday.

Lickskillet Farm Restaurant
Old Roswell Road, Roswell/475-6484. Dining with country elegance in a 140-year old farmhouse open from 6:30 p.m. Tuesday through Saturday.

The Magic Pan
Lenox Square/266-8424, Cumberland Mall/432-3115. Elegant French crepes in varied entrees and desserts. Garden-like atmosphere of a French country inn. Open 11 a.m. to midnight Monday through Friday; 11 a.m. to 1 a.m. Saturday and 11 a.m. to 9 p.m. Sunday.

Maison LaFite
3384 Peachtree Road, N.E./262-2215. Parisienne cuisine with undertones of Italian specialties. Open for lunch Monday through Friday, dinner 6 p.m. to 11:30 p.m. except Sunday.

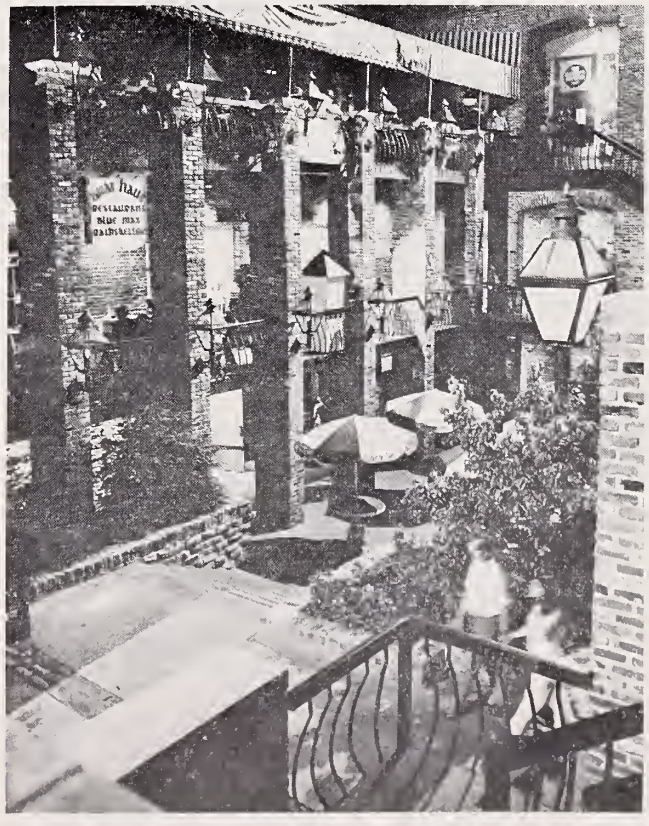
Midnight Sun
225-235 Peachtree St., N.E. in Peachtree Center/577-5050. Danish and unmatched in cuisine, service and ambience. Open daily except Sunday.

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25 Cain St., N.W./525-8228. Traditionally Old South in food and service with an hors d'oeuvres buffet of 22 items. Open 6 to 11 p.m., Monday through Friday; Saturday 5:30 p.m. to midnight.

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555 Peachtree St., N.E./874-3223 and in Phipps Plaza/261-6341. French cuisine in a delightfully intimate atmosphere. Open 6 p.m. to midnight, closed Sundays.

The Sandpiper
2960 Piedmont Road, N.E./266-1706. Atmosphere of casual relaxation with top entertainment in the cocktail lounge. Open for lunch Monday through Friday, dinner 4 p.m. to 11 p.m. Monday through Thursday, 5 p.m. to midnight Friday and Saturday; open Sunday 5 p.m. to 10 p.m.

Vittorio's Restaurant and Lounge
2263 Peachtree Road, N.E./355-0874. Romantic candlelit dining room with Roman cuisine and prime steaks. Open 5 p.m. to 2 a.m. except Sunday.



Appointment of a director of psychiatry for the state prison system heads the list of recommendations to improve current inadequate care for inmates.

Psychiatric Needs of Georgia Prisoners

JONAS ROBITSCHER, J.D., M.D., *Atlanta**

GEORGIA'S PRISON SYSTEM does little to take care of the acute psychiatric needs of its more than 10,000 inmates; some of the most disturbed are transferred temporarily out of the system into the mental health system and the rest are substantially ignored. It does even less for inmates with chronic but not attention-provoking psychiatric problems.

With non-psychiatrists providing evaluation and temporary care before a transfer to the Binion Building at Central State Hospital and only one psychiatrist working one day a week to deal with patients within the prison system, most of the severely psychotic and the psychologically maladjusted who make up a large proportion of the prison population are without any form of psychiatric treatment. This situation cannot be blamed on individuals working for the prison system. Our correctional systems are bureaucracies—the word is used descriptively, not critically—and they are hard to change. The money needed to improve the situation is not available. There are other factors in the lack of psychiatric services for prisoners.

Finding Qualified Psychiatrists

The correctional people I have met in Georgia are fine people and they run the best system they can under adverse circumstances. Although they are conscious of the psychiatric needs of prisoners, they are hard put to find good psychiatrists who want to work with prisoners. The criticism goes both ways—psychiatrists generally are not interested in the correctional field and, when they are, they often do not know how to work with correctional people.

One of the great problems is that prison psychiatry is a low-status and low-paying field; it does not attract many first-rate psychiatrists.

Many correctional psychiatrists work under institutional licenses; they lack the qualifications for a regular license and are themselves prisoners of their institutions, at least on a professional level. In other jurisdictions, some of the psychiatrists corrections attracts have been accused of getting undue pleasure out of their exercise of authority. Another problem is that although many psychiatrists would be interested in part-time prison work, consultants and part-time people in any bureaucratic system do not have a chance to be effective in producing new policies, so some of the best professional people working in the system have little impact on the system.

On a more psychological and less sociological level, the greatest contributions psychiatrists have to make to the correctional system—our ability to understand individual dynamics and our willingness to work over long periods of time to achieve personality changes—are antithetical to the need of correctional people to keep distant, impersonal, and removed from their charges both as a psychologically protective measure and in the interests of institutional security.

No states that I know of offer good psychiatric care to prisoners. Yet, it is usually estimated that from 10 per cent to 15 per cent of inmates are psychotic. They need diagnosis, chemotherapy, support, and often special protection from other inmates. Among more normal inmates, a number have had problems with drugs, alcohol, and neurotic symptoms. Although the average prisoner may be classified as a sociopath—and thus is seen as cold, manipulative, amoral, and difficult or impossible to treat—although most prisoners are said to be incapable of developing the kind of transference neurosis that makes psychoanalytically-oriented psychotherapy "go"—it is too easy to say that prisoners

* Henry R. Luce Professor of Law and the Behavioral Sciences, Emory University School of Law, Atlanta, Ga. 30322; chairman of the Medical Advisory Committee to the Department of Offender Rehabilitation. Abstract of a paper delivered at the fall meeting of the Georgia Psychiatric Association, Sept. 12-15, 1974 at St. Simons Island. Lloyd Baccus, M.D., director of psychiatry and law service and director of inpatient psychiatry at Grady Memorial Hospital served as moderator for the program.

cannot benefit from psychiatric help. Group therapy and counseling may be more comfortable for both patient and therapist than individual therapy; the psychiatrist may see his best role in supervising group leaders rather than in running groups himself —but there are certainly ways for psychiatrists to function in the system, and not only to give emergency aid to the acutely psychotic.

Committee Members

On September 1, 1973, the then-commissioner of Georgia's Department of Offender Rehabilitation, Ellis MacDougall, appointed a committee to consider the medical needs of the Georgia Prison System. I was appointed to the committee as the representative of the Georgia Psychiatric Association by its then president, Corbett Turner, and on the request of Commissioner MacDougall I served as the committee's chairman. The committee was charged to report back in 100 days—which turned out to be an impossible task. It had one full-time paid executive director, Steven Kermish, and a number of very hardworking volunteer members. Let me name Dr. Joseph Hertell, Dr. J. Wendell Glass who represented dentistry, Dr. Lloyd Baccus who is on the panel here today and who formerly served as medical director for the Department of Offender Rehabilitation, L. Pat Norton, research and planning director of the Atlanta Association for Retarded Children, and Dr. John Slade, at the time a fourth-year medical student who started out as a student observer of the Committee's work as part of his study of public health but who contributed so much to the Committee that he was appointed a member. Two "civilian" members of the Committee, appointed by Governor Carter to represent the public-at-large, also put in much time and effort on the task of the Committee; they were James L. Paulk of Fitzgerald and H. Zack Smith of Statesboro. The Committee has done its work—handed in its report and folded its tent—and to the best of my knowledge its recommendations concerning improvement of medical and psychiatric services have not yet had much impact on the prisons. I hope that this panel today will lead to positive changes.

The section on mental health services in our report begins with a clear statement on how inadequate we found mental care for Georgia prisoners:

> Georgia prisoners with acute psychiatric disturbances receive inadequate care in Georgia prisons. Usually, they are transferred to the unit for the criminally insane at Central State Hospital where they continue to receive inadequate care, although they are no longer the responsibility of the Department of Offender Rehabilitation.
>
> Prisoners who have long-standing psychiatric problems which do not grossly interfere with functioning in the prison ordinarily receive no care. They become part of the general population of the prison and are usually not identified or treated. Retarded prisoners share the same fate.

Although much of our attention was directed to acute emergency psychiatric care and care of the severely disturbed, there is perhaps an even greater need for more definitive psychiatric services for inmates who might use psychiatric help as someone in the "civilian" population might use psychiatric help—to deal with anxiety or excessive aggression, to develop better understanding of psychological dynamics, to help promote personality growth and change.

Some other states are beginning to do much more for prisoners psychiatrically than Georgia is doing, and although it would be a mistake to overvalue these present efforts this does indicate that society is beginning to recognize a responsibility. However, it also should be recognized that Georgia has moved toward the development of more comprehensive psychiatric and psychological services designed to deal with all inmates, not just psychotic inmates, through its Evaluation Psychological Reports Program which is located at Jackson and through pioneer Behavior Modification Programs which are now in effect in some institutions and which according to present plans will be extended to all facilities in the state's prison system.

The report comments favorably on the Behavior Modification programs at Jackson and Alto. The Jackson program was instituted by Commissioner Ault when he was warden at Jackson. The report reads:

> Although behavior modification techniques can represent a violation of the rights of inmates and have been seen so in other jurisdictions where psychosurgery and aversive conditioning using emetics or coma production have been used, the type of behavior conditioning used in Georgia has been, in the view of this Committee, benign. Since Georgia has used token economy systems rather than other "classical" conditioning techniques—emetics, shock therapy, drug therapy, psychosurgery, and other "clockwork orange" horrors—courts probably would view any invasion of the privacy of the inmate as minimal. The token economy as it is used in Georgia at present does not appear to intrude any further into the inmate's right to privacy than does prison life itself.

The report commends the work that has been

done in behavior modification in Georgia, but it points out that one danger of behavior modification is that other methods of producing change—individual therapy or counseling, group therapy, family therapy, marriage counseling, drug and alcohol programs—may suffer from a de-emphasis. Behavior modification is seen as possibly potentially less valuable than insight therapy but perhaps more suited to the needs of many prisoners.

Improvements Suggested

We recommended:

- That a director of psychiatry be appointed for the Georgia Prison System, that he be empowered to make plans for gradually increasing services to inmates, that all efforts be made to provide a full and comprehensive range of psychiatric services for all prisoners by not more than the expiration of five years, and that a continuing advisory board consisting of a representative of the Georgia Psychiatric Association, the Georgia Psychological Association, representatives of the Departments of Psychiatry of the Medical College of Georgia and Emory University School of Medicine, representatives of the Georgia Mental Health Association, and lay people interested in mental health be set up to assist the director in formulating his long-term plans and to provide a continuing source of advice and counsel.
- The building of a prison facility with a suggested capacity of 150 beds for acutely disturbed inmates, the facility to be built close to an existing medical school so that consultants will be available and residents can have learning opportunities.
- A clarification of the guidelines of the practice of prison psychiatry so that inmates can feel assured their therapeutic relationship is non-punitive and is divorced as far as practicable from the prison administration.
- Increased emphasis on counseling and therapy in all institutions.
- Increased emphasis on alcohol and drug treatment programs with special attention to the transitional period as the inmate leaves the institution.
- Cooperation with aftercare agencies.
- Greater use of contract physicians and other part-time personnel.
- Identification of the retarded and planned programs for their education and rehabilitation.
- Greater availability of Behavior Modification programs.

The area of personnel recruitment and civilian supervision of prison psychiatric programs is where I think the Georgia Psychiatric Association can make its greatest contribution. This is a period when American psychiatry is recognizing its obligation to the underprivileged. This year in a notable position statement, the Trustees of the American Psychiatric Association said that incarcerated individuals have a right to adequate medical services, including psychiatry. " . . . An essential part of a minimum medical care-delivery system consists of the early detection, diagnosis, treatment, and prevention of psychiatric illness. Many 'correctional' facilities are not so structured as to supply this care-delivery system even minimally."

The fact of most reports, such as the Medical Advisory Committee Report, is that they are largely forgotten except to the extent that some selected recommendations can be used as an argument with the legislature to secure funds for special projects. I think we are prepared to have our report meet this fate, and we would still feel we had accomplished a major purpose if today's discussion helps to produce more input into correctional psychiatry by psychiatrists who have not yet been involved in this area of need. ■

Panel Discussion

Edward S. Lundell, M.D.
Medical Director, Georgia State Prison,
Reidsville, Georgia (at the time of this panel discussion)

It is very easy for those on the outside to criticize what's happening on the inside. It was stated in the Medical Advisory Committee Report that there is little or no danger to those who work in the prison. I just wanted to set that record straight. Believe me, there is. When you have 2,800 inmates to care for, medically and physically, and at least 100 are moving more or less at any one time freely along your medical corridors, believe me, danger is there. Whenever there is a bloodletting, I am usually in the middle of the blood. We at Georgia State Prison feel that we are trying very hard to make things work.

J. Frank Casey, M.D.
Consultant, Diagnostic and Classification Center,
Jackson, Georgia

An observation I have made that has been rather helpful to me is about the philosophy of the public in general. If you ask somebody on the street, you'll be told that a man who has been convicted of a crime has got to go to prison, pay his penality, behave himself, and then he can get long alright. Well, I've found that that's not so easy to do, because those inmates are all

under terrific pressure. For instance, the man who tries to mind his own business may be approached by a bunch of guys who are planning an escape, and if he refuses to go with them he's in a bad way. So it's not as easy as one would think to go in and behave oneself and come out alright. Another problem comes up when an inmate becomes acutely depressed, which in ordinary psychiatric terms we would consider a relatively short-lived depression providing he can get the kind of treatment he ought to have. But under the circumstances he won't get it, because the system doesn't provide it.

One other point I would like to bring out is that the doctor, and particularly the psychiatrist, has got to develop a rapport with these people if there is going to be any benefit whatever. Except in extreme cases such as the planning of a murder, you have got to respect the confidences they give. The inmate needs someone in whom he can confide and feel that the law is not going to interfere. In this sense it is an advantage to have a therapist or evaluator who is not a part of the formal system itself who can say, "Look, I work here, but I am not a part of it." That seems to develop a certain amount of confidence that I don't believe could be otherwise.

Julius Ehik, M.D.
President, Georgia Psychiatric Association;
Medical Director, Metropolitan Psychiatric Center;
Psychiatric Consultant to the Cobb County
District Attorney's Office

I am not quite sure that anyone could define the real purpose of our correctional system. Is this system for the purpose of punishment? To separate some people from our society? To rehabilitate inmates? Is it supposed to be a deterrent or therapeutic community? Because psychiatrists and other disciplines dealing with human behavior are primarily rehabilitation oriented, it is under criticism by those who feel that the primary function of the system is that of punishment.

The concept of rehabilitation of the offender is indeed a very complicated one, especially since I feel that meaningful rehabilitation has to be highly individualized and cannot be carried on a collective basis. In our correctional system in the past, great emphasis was put on job training assuming that providing inmates with a skill will prevent the offender resorting to crime. It is obvious that this concept could only be applied to a very small percentage of inmates.

Finally, I would like to comment as to the personnel involved with the inmates. While I understand that recently there has been an improvement in the training program of the correctional officers, from my experience in my dealings with our correctional system I feel that there is still much to be desired in this aspect. I hope that in the future a closer relationship could be developed between the psychiatric community and the correctional system and that more psychiatrists will be utilized in the capacity as teachers helping the correctional officers to understand and deal more efficiently with the offender.

Dr. Allen Ault
Director, Department of Offender Rehabilitation

During my first year at the Georgia Diagnostic and Classification Center, 4,500 people came through that facility. There were 8,100 inmates in the system at that time. There are now 10,117, and we have lost 12 facilities since that time, both county and state. We have 10 pounds of people in a five-pound can. I worry day to day whether the facilities we have won't fall down around their ears. If everything remains the same as it has over the last 13 quarters, our computer projections indicate that by 1980 we will have 44,000 inmates in this state. If everything remains the same as over the last 12 months, we will have 55,000 inmates by 1980. This year we have requested a 70 per cent increase in the budget—that won't quite meet survival.

Our psychiatric services have not improved—we have good quality—it's just the quantity we're worried about. I don't think the current prison system is going to make any impact at all on some people. We are still at 65-70 per cent recidivism rate, and if we really are not going to have 44,000 inmates we will have to do something drastic. We are trying to work through new concepts in communities and try diversion programs and alternatives to incarceration. We are trying new concepts in restitution centers, where for the first time an inmate can take responsibility for his actions and make restitution to his victim. The Youthful Offender Act was probably the most successful act that has ever been passed in Georgia. That's where we've sent people from 17 to 24 for an indeterminate sentence and we sign a contract with them after they go through the Diagnostic Center, and it's up to them when they get out. They need remedial education, or a high school education, or vocational training, or group therapy, or whatever—they have to complete it. The day they complete it, we let them out. We have had less than nine per cent recidivism rate in this program.

For the first time we are working closely with the legislature and having a lot of input from them. For one of the first times we are having a close relationship with judges with a lot of input from them and a lot of input from the medical and psychiatric and psychological communities.

Mr. Hugh Hendricks
Health Services Arministration,
Department of Offender Rehabilitation

The Department needs some friends who can help us. Help us in planning, organizing, and implementing a systematic approach to improving the mental health care capabilities for our inmates.

Generally, I think we can break our thinking into three categories:

1. A conceptual system of organization. How do we intend to go about providing psychiatric care? What resources, what capabilities within the state and nationally can we put together?

2. The selection and appointment of a Psychiatric Advisory Board for the Department of Offender Rehabilitation, then the employment of a director of psychiatric care, and then a designed organization of carefully located people, centrally and regionally, to provide this care.

3. Finally, I think we need regionalization of psychiatric evaluation and care. I would like to see, just as we have regional mental hospitals for the Division of Mental Health, that we have evaluation and treatment provided for non-acute cases out in the regions for our prison system.

Our present system of trying to bring everyone into

a central location, such as Reidsville, Jackson, or Milledgeville, often multiplies the problems.

Jones Robitscher, J.D., M.D.

I think that as long as we operate institutions out in the boondocks, far from metropolitan centers, we can't expect two kinds of people to become involved in them. We can't expect academic people to become involved, and we can't expect private practitioners to become involved. And, still, it seems to me that these two groups of people, academic people and private practitioners, really have a tremendous amount to offer.

Mr. Hendricks talked about possible new facilities; I think our committee would urge most strongly that no matter how many beds, no matter how much money is spent, even if the facility has to be stripped to a minimum, even if all luxuries have to be foregone, even if this new facility doesn't have the latest medical-technological equipment, having it located where people who haven't been involved previously can be called upon geographically and logistically, is something to which we should give the highest priority. ■

DIRECTORY ASSISTANCE CHARGE BEGINS; HANDICAPPED USERS ARE EXEMPT

The new 20 cent charge for directory assistance has gone into effect for Southern Bell Telephone users, but the company reiterates that persons with visual, physical or mental handicaps will be exempt if they file a certificate with the company.

A ruling by the Georgia Public Service Commission allows the company to grant the customer five calls to directory assistance each month without charge. After this limit, a 20-cent charge per call is imposed. Long distance calls are exempt if the caller is not trying to find a number within his own area code. Those calls, in turn, will be exempt if they are balanced by an equal number of long distance calls for that month.

The charge has been imposed as a cost saving measure that is designed to cut down in the number of directory assistance calls and to encourage callers to use their telephone directories. Those dialing from hotel rooms, pay phones and hospital rooms will not be charged.

Handicapped users desiring exemption must contact Southern Bell's business offices for the necessary forms. Among the information requested is the name of the "*physician,* clinic, social agency or other person or organization who can furnish additional details, if needed, concerning this situation. . . ." Please keep in mind patients who might qualify for and benefit from this exemption.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL* IS NOT *AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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A Disappearing Colon Tumor

LEWIS DAVIS, JR., M.D., *and* HANS TSCHERSICH, M.D., *Atlanta**

DR. LEWIS DAVIS: The case for presentation is a 55 year old male with a history of three weeks intermittent periumbilical pain with several episodes of melena. These are representative films from the barium enema examination. Dr. Tschersich, would you comment on these? (Figure 1).

Dr. Hans Tschersich: The most obvious and striking finding is the presence of a large mass lesion in the transverse colon. This is present on both pre-evacuation and post-evacuation films. This has the appearance of a very large colonic polyp. The mucosa is intact over this lesion and has a smooth outline. An adenomatous polyp of this size brings up the question of adenocarcinoma.

Dr. H. S. Weens: What other tumors would you think of besides adenomatous polyp or adenocarcinoma? Are there any benign tumors which may present with this appearance? Is this elongated sausage-like configuration suggestive of any type of benign tumor?

Dr. Tschersich: Lipoma arising from the colonic wall may present with this configuration.

Dr. Weens: You are right, lipomas may frequently present with this elongated appearance. There is a method of studying lesions which are suspected to be lipoma with a plain water enema to demonstrate the increased fatty content of the tumor in contrast with the water density. Was this examination done on this patient?

Dr. Davis: A water enema was not performed, although it was recommended by the Radiology Department. The fixed nature of this lesion was confirmed by two examinations and the patient underwent surgical exploration approximately 7-10 days following the barium enema examinations.

At surgery, no large bulky lesion could be found in the colon. Only a very small polypoid lesion was found which is demonstrated in this gross specimen (Figure 2). You can see that the lesion is a broad-based polypoid structure less than 1 cm. The superior aspect of this lesion is ulcerated indicating that the bulky portion of this polypoid lesion has sloughed off. Dr. Someren, would you comment on the pathology of this lesion?

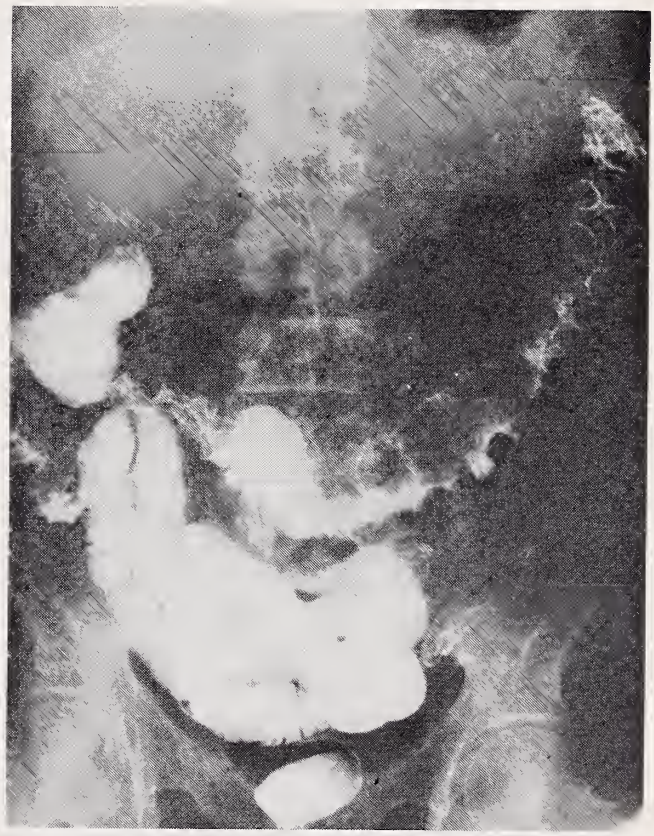


FIGURE 1

Post-evacuation barium enema film demonstrating a large mass lesion on the left side of the transverse colon.

Dr. A. Someren: The histological section of this lesion demonstrates the ulcerated superior aspect with intense inflammatory reaction and granulation. The bulk of the lesion is a mixture of fat and fibrous tissue with associated vascular tissue. This may be referred to as lipoma, angiolipomatous variation of lipoma or hamartoma. This represents a lesion which is benign and is basically made up of normal fat.

Dr. Weens: Perhaps the sloughing of the large bulky tumors of lipoma are a common thing. We have seen similar incidences to this one in the past.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

Perhaps the recurrent episodes of bleeding associated with this type tumor indicates ulceration and sloughing of the bulky tumor from its base.

Comment

Although relatively uncommon, lipomas of the colon are the next most common benign tumors.

Clinically lipomas may cause intermittent abdominal pain. There may be ulceration with bleeding, constipation, intussusception or obstruction.

The differential diagnosis includes carcinoma and adenomatous polyp. A pre-operative diagnosis would influence the type of surgery as a polypoid adenoma of questionable benignity and carcinoma calls for resection of the involved colon. The suggested procedure for lipomas is resection of the tumor only, or observation without surgery.[2]

The roentgen findings are typical enough to recognize lipomas in a significant number of cases. They are submucosal and occur anywhere in the colon but more often in the ascending colon and cecum. On x-ray examination, lipomas are smooth, relatively radiolucent, sharply outlined with intact mucosa. Often they are quite large, pliable and tend to mold in conformity with the colon lumen.[3] Margulis and Javanovich advocate plain water enemas and low KV technique to accent the increased radiolucency of the lipoma.[2] Nelson and Rogers observed that two out of seven cases expelled the lipoma prior to surgery leaving only an ulcerated pedicle.[1] This occurred most likely in the present case. Repeat barium enema before surgery would be advisable to assure that the lipoma has not sloughed. ■



FIGURE 2

Photograph of the excised lesion of the transverse colon demonstrating a broad-based polypoid structure less than 1 cm. in diameter with ulceration representing the base of the sloughed bulky lipoma.

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AMA TO SPONSOR NATIONAL CONFERENCE ON DISABLED PHYSICIANS

Alcoholism, drug dependence and mental disorders existing in the physician population will be the major theme of a national conference on the "Disabled Psysician," April 11-12, sponsored by the American Medical Association.

Headquartered at the St. Francis Hotel in San Francisco, this meeting will attract some 300 medical authorities representing various specialties. Participants will examine the motivational aspects, as well as appropriate mechanisms, for encouraging doctors with these disabilities to seek advice and treatment.

Accented during this two-day meeting will be accountability to the public through the assurance of competent patient care. Conference speakers and attendees will focus on exploring alternative formal and informal procedures for the effective treatment, rehabilitation and disciplinary action, when necessary, of the disabled physician.

The role of the medical society, relationships with state licensing bodies, and legislative support mechanisms will be other areas of discussion. Featured on the program are workshops on treatment modalities, treatment facilities and physician re-entry into professional life.

Also, there will be a discussion session devoted to practical ways of implementing AMA's model legislation, the "Disabled Physicians Act," which takes the form of a uniform state law. Preventive rather than punitive in nature, this draft bill would establish the state medical society as an agent to the state licensing body in this particular problem area.

Failing other more informal procedures, the model legislation provides for restriction, suspension or revocation of a practitioner's license for reasons arising out of physical or mental illness, including drug dependence and alcoholism.

Further information on the conference is available through AMA's Department of Mental Health, 535 N. Dearborn St., Chicago, Illinois 60610.

editorials
editorials
editorials

Welcome to Atlanta

WE ATLANTIANS LOOK FORWARD to April. All of the trees, which we struggle with through the winter of broken limbs and disrupted power lines, seem to blossom forth in grateful appreciation and give us one of our most beautiful assets. People seem to share more than their usual friendliness and hospitality.

This year we look forward to having MAG with us in April. I hope all of our city will be in full springtime attire and attitude for you. I extend a very hearty welcome on behalf of the Medical Association of Atlanta and wish you a most successful meeting.

William D. Logan, Jr., M.D.
President
Medical Association of Atlanta

Introducing the Scientific Session

WHATEVER HAPPENED TO THE ANNUAL scientific meetings MAG used to sponsor? Well, they're returning this fall in a remodeled version.

Time was when the state specialty societies offered good educational programs in conjunction with MAG's Annual Session in the spring. However, this arrangement had the unhappy effect of tugging doctors in the two opposite directions of science and politics. Consequently, MAG's House of Delegates voted in 1973 to divide the business and scientific portions of the Annual Session and to hold the latter meeting in the fall.

There was no scientific meeting in 1974 because the organizers did not feel that they had enough time to plan for the kind of quality program desired. Meanwhile several steps have been taken to insure the quality of the 1975 Scientific Session. MAG's Education Committee, working in consort with the Interspecialty Council, has solicited the participation of a number of specialty societies in the meeting. Each society, aided by substantial MAG funds, will design its own program and select its own speakers. In addition, MAG's new Assistant Executive Director for Education has undertaken as one of his most important assignments the coordination of planning efforts for the meeting. All systems are GO, then, for MAG-sponsored continuing medical education in 1975. We have not confirmed final dates yet, but we can tell you that the meeting will be in mid-November.

The 1975 Scientific Session will feature quality postgraduate medical education in traditional format along with several attractive extras. For instance, we are planning for the attending wives a parallel educational program in such fields as the arts and humanities. In addition, MAG will sponsor a luncheon (featuring a nationally-known guest speaker) and a cocktail party. Finally, the Scientific Session will be followed immediately (and at the same location) by

MAG's annual MAGNET Conference, for which many of you will want to stay the extra day.

The 1975 Scientific Session promises to be a bold and exciting venture on our part. We hope you will make plans now to be with us in November.

Stephen L. Daniel, Ph.D.
Assistant Executive Director,
Education

Letter to the Editor

Dear Sir:

"The Year of the Nevus," an editorial written by me that you published in August 1974, elicited a number of letters and comments. Most were favorable, supporting the editorial.

Unfortunately and quite unintentionally, it appears that I insulted every plastic surgeon in Georgia by using as an example of what I consider an excessive fee, one that was charged by a plastic surgeon for removing a mole. The Georgia Society of Plastic Surgeons asked me to document this by giving them the name of my friend who was charged this fee. This I will not do; there the matter rests.

So I feel that I should apologize to the plastic surgeons as a group and individually to those plastic surgeons who do not charge excessive fees. The editorial could have been written about internists who charge $300 to $400 for "complete evaluations" on healthy young people. It could have been written about surgeons of one type or another, who do unnecessary operations, regardless of the fee charged. It could have been written about "shot doctors" or "fad doctors" or a variety of others, both generalists and specialists. It so happened that I had what I considered a funny story about a mole and another about a friend whose veracity is unquestioned. Therein lay the source of an editorial about fees that I was asked to write.

The conclusion reached in the editorial remains valid regardless of the story used to illustrate it: Each time a patient is overcharged, all physicians lose a little something. It adds grist to the bureaucratic mill that is already grinding out new laws to regulate the practice of medicine. The conditions demanded by HEW in the future will be draconian by present standards. For this, the average, could-care-less but clean-nosed physician can thank three groups: the few avaricious physicians that we have in our profession; many of our medical leaders who find it more expedient to look the other way than to try to do something about exorbitant fees; and themselves, for not caring enough until it is too late.

Nicholas E. Davies, M.D.
35 Collier Road, N.W.
Atlanta, Georgia 30309





New state legislators were entertained with a cocktail party and buffet supper in the galleria in the Memorial Arts Center in January. Enjoying the evening (left) are Rusty Kidd, MAG legislative representative; House Speaker Tom Murphy; MAG President J. Rhodes Haverty, M.D.; Lt. Gov. Zell Miller; and Charlie Templeton, director of public and professional relations. Among the new legislators and their wives sampling the buffet are Dr. and Mrs. Wilbur Baugh of Milledgeville.

president's letter

Business and Scientific Sessions Separate in 1975



WE'VE CHANGED THE WHOLE THING! Instead of our usual yearly Mother's Day meeting, we've scheduled this year's Annual Session for April 18 through the 20, also smartly and neatly avoiding Easter as well! And on top of that, we are booked at Atlanta's exciting new Fairmont Colony Square Hotel.

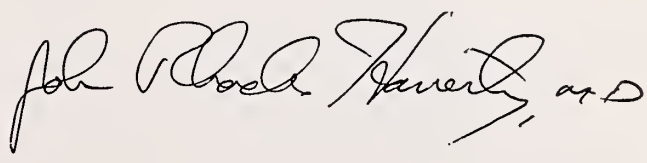
This year will combine business sessions of the House of Delegates with the usual meetings of the Executive Committee and Council, which are open as always, and each MAG member is encouraged to attend. In addition, other meetings of general interest to members of the Medical Association will take place.

The previously enjoyed concomitant scientific sessions will be held in the fall as our first effort in separating these two activities. The fall meeting, set for November in Atlanta, already has had much planning, and bodes well for a stimulating and educational experience. Aside from MAG speakers and social functions, many of the specialty societies will be participating by having their own scientific or business meetings at this time. Be sure to check your own specialty society program plans. In addition, we have scheduled this scientific session immediately preceding the annual MAGNET conference, so that our members can take advantage of both activities with the least time spent. And of course, the November dates allow for Christmas shopping for you and your spouses.

Our Annual Session this year will include the several reference committee deliberations, and the House of Delegates debates on those issues of critical importance to medicine today. The general meetings also will include:

- the presentation of awards and certificates of merit;
- a special panel discussion concerning our new disciplinary procedures, with members of the Composite Board of Medical Examiners participating;
- another stirring and fun-filled GaMPAC breakfast;
- a presentation by James Sammons, M.D., executive vice president of the AMA. It is expected that Dr. Sammons will give us considerable insight into the AMA financial situation, and other crucial issues facing our national organization.

So, although changed in many respects, we still have enough "old" to make you feel comfortable, with enough "difference" to entice you. Plan to attend the Annual Session in April, and make your plans now to attend the fall MAG Scientific Sessions as well.



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

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Cancer Education—What's New This Year?

LAMAR S. MCGINNIS, JR., M.D., *Decatur**

"WHEN DO WE PALLIATE OR TREAT for cure in pancreatic malignancy?" . . . "Are there any new diagnostic tools available to help find this cancer?" . . . "Colonoscopy for colon polyps?" . . . "Abdomino-perineal resection . . . or electrocautery . . . which should we use in the treatment of cancer of the rectum?" . . . "What do I do with a solitary thyroid nodule? . . . Take it or leave it?" . . . "Is the scan the answer?" . . . "What about radiation therapy . . . endocrinology?" . . . "Positive biopsy: endometrial—who treats first?" . . . "Chemotherapy: hormones vs. poison?" . . .

These are a few of the questions that will be answered during the forthcoming programs on cancer for physicians this spring, under the direction of the Professional Education Committee of the American Cancer Society, Georgia Division, Inc.

Annual Day of Cancer

The Seventh Annual Day of Cancer, to be held in conjunction with the Atlanta Graduate Medical Assembly on March 11 at the new Fairmont Colony Square Hotel in Atlanta, has become a program physicians from throughout Georgia look forward to each year. The emphasis of this year's program is on colon and rectal cancer, pancreatic tumors, cancer of the stomach, abdominal tumors in children, and Hodgkin's disease, and will provide something for every modality and specialty.

An outstanding faculty from New York, Pittsburgh, Rochester, Minnesota, and Cleveland has been enlisted. Dr. Seymour I. Schwartz, professor of surgery at the University of Rochester, will moderate the morning panel discussion on "Pancreato Biliary Malignancies," with Dr. John L. Madden of Saint Clare's Hospital and Health Center in New York City; Dr. William H. ReMine of Mayo Clinic; and Dr. Mark Ravitch of Montefiore Hospital in Pittsburgh, participating in the discussion with him. Dr. Rupert Turnbull of Cleveland Clinic and Dr. Madden will discuss "Cancer of the Right Colon, the Isolation Technique Method of Resection with Results" and "Cancer of the Rectum."

The luncheon panel discussion will be an important introduction to the entire afternoon program, with the above physicians discussing "Malignant Tumors of the Colon and Rectum."

During the afternoon Dr. Schwartz will provide an opportunity to learn some of the latest information available in the treatment and management of "Hodgkin's Disease"; Dr. Ravitch will talk about "Abdominal Tumors of Children"; and Dr. ReMine will bring physicians up to date on the "Current Status of Cancer of the Stomach." This is an outstanding program that should be of interest to all physicians in Georgia who are seeing cancer patients. Those who may not have received

* Chairman, Professional Education Committee of the American Cancer Society, Georgia Division, Inc. Dr. McGinnis, a surgeon, is in practice at 365 Winn Way, Decatur, Ga. 30030.

the official brochure and registration form may contact the American Cancer Society, Georgia Division, 2025 Peachtree Road, N.E., Atlanta, Ga. 30309; or the Atlanta Graduate Medical Assembly, 875 West Peachtree St., N.E., Atlanta, Ga. 30309.

Callaway Cancer Seminar

The second program of importance to Georgia physicians is the Fourth Annual Cancer Seminar at Callaway Gardens, on April 25 and 26. This annual spring event is one physicians in Georgia, particularly in Southwest Georgia and Eastern Alabama, like to attend because it offers them the opportunity to bring their families, play a little golf, fish and swim if they wish, and yet have an outstanding learning experience with it.

This year's program concentrates on thyroid cancer and cancer of the endometrium and ovaries. Outstanding speakers include Dr. Edgar C. Whitehead, Department of Surgery, and Dr. J. Taylor Wharton, associate gynecologist, both of M. D. Anderson Hospital and Tumor Institute in Houston, Texas; and Dr. Newlon Tauxe, professor of nuclear medicine and clinical pathology at the University of Alabama School of Medicine in Birmingham. Georgia physicians participating on the program include Dr. Jack Blalock, an internist from Columbus; and Dr. Herbert E. Brizel, radiation therapist of Augusta. Dr. Hoke Wammock of LaGrange, Dr. John D. Watson and Dr. David B. Roberts of Columbus, and Dr. James Achord of Macon will serve as moderators and chairmen of this program.

If official programs and registration forms have not been received, contact should be made at Holiday Inn at Callaway Gardens for both room and golf reservations. Further information on the program may be received by contacting the American Cancer Society, Georgia Division, Inc., 2025 Peachtree Road, N.E., Atlanta, Ga. 30309. ■

"THE VIOLENT SELF—THE VIOLENT SOCIETY"

Violence, a subject of increasing concern in contemporary America, is the topic for a symposium at Emory University that will include speakers ranging from Bill Curry of the Los Angeles Rams to Dr. Alvin Poussaint, black psychiatrist from Harvard.

"The Violent Self—The Violent Society" is the title of the symposium set for April 18 at Tull Auditorium in Gambrell Hall, home of Emory University's law school.

Appearing in the morning sessions will be Dr. Stefan Pasternack, Georgetown University School of Medicine, speaking on "Violence in Ourselves"; Dr. Poussaint of Harvard Medical School, "Racial Violence"; Dr. Lloyd Baccus, Emory Department of Psychiatry, "Political Assassins."

Moderator for the morning sessions will be Dr. DeWitt Alfred, chief of service, Department of Psychiatry, Grady Memorial Hospital. Other participants will include Dean L. Ray Patterson of Emory's law school and Dr. Bernard Holland, chairman, Department of Psychiatry at Emory.

Speakers in the afternoon will include Dr. Melvin Heller, co-director, Unit in Law and Psychiatry, Temple University, "Violence in Television"; Bill Curry of the Los Angeles Rams, "Violence in Sports and the Spectator"; Dr. Albert Stone, Institute of Liberal Arts, Emory, "Violence in Literature."

Dr. Jonas Robitscher, Henry Luce Professor of Law and the Behavioral Sciences at Emory, will moderate the afternoon sessions.

Registration fee is three dollars. More information can be obtained from Dr. Robitscher's office, (404) 377-2411, ext. 7901. The symposium is sponsored by Emory and Grady Memorial Hospital.

ATLANTA SITE FOR AMA SOCIOECONOMIC CONGRESS

It's not too early to mark your calendar for the 9th AMA Socioeconomic Congress, held at the Regency Hyatt Hotel in Atlanta, April 25-26. Sponsored by the AMA Council on Medical Service and the Medical Association of Georgia, the one and a half day meeting will focus on national health insurance.

Other participating organizations include the American Hospital Association, Blue Cross Association, Health Insurance Association of America, and the National Association of Blue Shield Plans.

The registration fee is $50. For further information, write to the AMA, Division of Medical Practice, 535 N. Dearborn St., Chicago, IL 60610.

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Vasodilators and Myocardial Infarction

ARTHUR J. MERRILL, JR., M.D., *Atlanta**

SINCE THE ADVENT of the coronary care unit, arrhythmia deaths from myocardial infarction have been minimized and the majority of in-hospital deaths from myocardial infarction (MI) are now caused by, or at least associated with, cardiac pump failure rather than primary arrhythmias. Emphasis in improved management of MI has therefore shifted from arrhythmias to prevention and treatment of congestive failure and cardiogenic shock.

In pathologic studies it is apparent that cardiogenic shock does not occur until 50 per cent or more of the myocardium has been destroyed.[1] This destruction occurs not only at the onset of MI but in many cases may continue in the peri-infarction zone during convalescence without further pain.[2] Preservation of this ischemic myocardium is an important goal and depends on achieving a positive balance between oxygen supply and demand in the peri-infarction zone. Oxygen supply is determined primarily by blood flow which is dependent on collateral and diastolic blood pressure. Metabolic demands are increased with increased heart rate, contractility (e.g. from Isuprel), heart rate, and arterial pressure. Studies in animals and humans have demonstrated a decrease in MI size when mean arterial pressure is lowered to around 80 with nitroglycerine even if only minimally elevated initially.[3, 4] MI size is increased with abnormally elevated arterial pressure or with the use of Isuprel.[5]

MI Size, Cardiac Output

Recently, nitroglycerine has been shown to decrease predicted MI size in dogs in spite of mild tachycardia and hypotension; when pre-treatment blood pressure was maintained with methyoxamine MI size was even smaller.[3] In addition, fibrillation threshold in dogs with MI is raised by nitroglycerine.[6, 7] Nitroglycerine and other vasodilators such as nitroprusside have been shown to increase cardiac output up to 30 per cent and decrease left ventricular volume and left ventricular filling pressure (LVFP) in patients with myocardial infarction and heart failure even without changes in arterial pressure or tachycardia.[8] All vasodilators reduce the amount of regurgitation as well as left ventricular volume in patients with chronic and acute mitral regurgitation. There is usually a large (up to 50 per cent) increase in forward cardiac output and little change in blood pressure (–16 per cent). Vasodilators given to patients with MI without heart failure or regurgitation or with LVFP less than 15mmHg causes a significant increase in heart rate and a fall in arterial pressure without increasing cardiac output.[8, 9] In addition, nitroglycerine has been shown to increase collateral blood flow in the ischemic areas at the time of open heart surgery.[10] In patients with myocardial infarction, cardiac output has been shown to be maximum at an LVFP of between 14-18mmHg.[11] Recently, systemic

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arterial pressure (SAP) was shown to be a major determinant of the LVFP and thus probably cardiac output in the first week after myocardial infarction.[12] Pharmacologic elevations in SAP cause elevations in LVFP and LVFP fell if SAP was reduced.

How does this relate to the treatment of myocardial infarction in the clinical setting? In a group of MI patients treated with vasodilators, mortality in 33 patients with moderate congestive failure was only 9 per cent and mortality was only 42 per cent in 40 patients with severe pump failure and/or cardiogenic shock.[8] These results suggest that vasodilator therapy may alter the unfavorable mortality in infarction with congestive failure and/or cardiogenic shock.

Recommended Uses

Therefore, the following uses for vasodilators are recommended in myocardial infarction:

1. At the present time, good risk patients with small infarctions and no heart failure probably should not receive vasodilators unless blood pressure remains elevated (systolic > 120-130, diastolic > 90) after the pain is relieved. In the latter group, lowering of pressure to more normal levels should be attempted either with nitrates (sublingual isosorbide dinitrate 5-10mg q2h, or isosorbide dinitrate orally 20mg q4h) or conventional anti-hypertensives such as methyldopa.

2. Patients with congestive failure and MI: mild failure may respond to diuretics, but, if these patients show signs of vasoconstriction or if mean BP is above 100mm Hg, give nitroglycerine, 1/150gr., sublingually. If systolic blood pressure falls less than 20mmHg then start either sublingual isosorbide dinitrate 5-10mg q2h or oral isosorbide 10-30mg q4h, depending on the response. This can be supplemented by diuretics and digoxin as needed. If significant hypotension occurs following nitroglycerine the patient probably is volume depleted and the foot of the bed can be elevated to increase venous return immediately. Because of the critical importance of LVFP in hypotensive patients, insert a Swan Ganz floating balloon catheter into the pulmonary artery and follow LVFP. Then slow volume expansion with Dextran or other expanders can be tried.

3. Severe congestive failure and/or shock: float a Swan Ganz catheter into the pulmonary artery and measure the LVFP. If more than 20mmHg, begin nitrates as above and diuretics even if the systolic pressure is low. Others have used an infusion of nitroprusside, 16-40 micrograms/minute as a dilator. If pressure falls further, then give aramine or norepinephrine to raise systolic pressure to 80 or 90.

The level of systolic pressure is less important if peripheral vasoconstriction, sweating, and confusion disappear; urine flow increases; and dyspnea improves. The goals of vasodilator and diuretic therapy are to maintain adequate peripheral perfusion and urine output and keep LVFP between 14-18mmHg. Following LVFP early in cardiogenic shock is critical because some patients have low filling pressure and require volume expansion and changes in dilator dosage and diuretic or fluid therapy may be necessary to keep LVFP at the ideal level of 14-18mmHg.

4. Finally, patients with MI, mitral regurgitation of ventricular septal defect, and congestive failure should have LVFP monitored with a Swan Ganz catheter; and, if a large V wave or significant shunt is found, vasodilators should be given as above. The author has had patients in shock in whom large V waves of 45mmHg decreased to less than 20mmHg, peripheral blood flow increased, and who began to diurese without further diuretics.

In conclusion, vasodilators are very useful in severe heart failure, cardiogenic shock or mitral regurgitation associated with MI. LVFP must be monitored to prevent relative hypovolemia and assess therapy. In patients with milder heart failure or hypertension dilators may be tried but should be discontinued if hypotension supervenes (systolic pressure < 100). Experimental studies suggest that dilators may be beneficial in preserving myocardium in all infarction patients but more work must be done before routine use of nitrates or other dilators can be

recommended. With further experience in patients with heart failure, those who do not develop hypotension following nitoglycerine can probably receive nitrates without monitoring left ventricular pressure. ■

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HEXACHLOROPHENE LINKED TO BRAIN DAMAGE IN PREMATURE NEWBORNS

The best bath for a newborn baby is no bath, according to the American Academy of Pediatrics' Committee on Fetus and Newborn. In a statement published in the December issue of *Pediatrics,* the Academy's monthly scientific journal, the Committee recommended:

- No cleansing of the newborn until the infant's temperature has been stablized after delivery.
- Rinsing of the head and face only with cotton soaked in sterile water or a mild nonmedicated soap with careful water rinsing. The remainder of the skin should be untouched unless grossly soiled. This leaves on the baby the vernix caseosa he is born with, a waxy film that may protect the skin and peels off in a few days.
- Rinsing of the diaper area with sterile water and cotton or a mild nonmedicated soap with water rinsing as required.

In the event of an outbreak of infection in the newborn nursery the Committee recommended a total program of infection control. If total body bathing of infants in pHisoHex occurs, the Committee emphasized it must be limited to full-term infants, thoroughly washed off after application and be applied no more than two times to each infant.

Up to two years ago when the Food and Drug Administration removed pHisoHex from over-the-counter sale, newborn infants were customarily given whole body baths in full strength pHisoHex in order to combat possible infection.

The Committee's statement appears in the same issue of *Pediatrics* as an original research article from the University of Washington School of medicine, Seattle, which reports on brain damage in children caused by hexachlorophene baths.

Researchers studied the autopsy results of 248 children over a seven year period. They found that repeated whole body bathing of premature newborn infants in full-strength pHisoHex was associated with disruption of the myelin of axons in the brainstem reticular formation. Small holes had formed in the brain cells of a number of prematures studied who had had two or more baths in full-strength pHisoHex.

This brain damage occurred predominantly in the 82 premature low-weight infants. Only four cases were found in the 90 larger premature infants and none among the 76 children who were full-term babies. Forty-three stillborn infants' autopsies were also studied. No such brain damage was found.

Certificate of Need

J. WINSTON HUFF, *Atlanta**

MANY CURES HAVE BEEN SUGGESTED to control rising hospital costs. One of the most prominently mentioned measures of late is the so-called "certificate of need" law. This type of legislation is that which requires a governmental agency to find a "public need" to exist prior to the construction or expansion of health facilities.

On the federal level, Hill-Burton has long required a finding of appropriateness by a state planning agency before federal funds can be obtained for hospital construction. On the state level, however, similar legislation has come much later.

Public Convenience and Necessity

The first certificate of need law was enacted in New York in 1964. Since that time approximately 25 states have followed suit. These laws impose extensive regulatory control on the construction and expansion of hospitals, nursing homes and other health care facilities and services. The certificate of need approach is basically the same as is used in the regulation of public utilities, railroads, truck lines and the like: no new or additional health facilities or services can be provided unless it is shown to be required by "public convenience and necessity." Strangely enough, there has been very little litigation reported involving the validity of these state laws. Two cases are most often cited and the two reach completely different results. In both cases the certificate of need law was challenged on the ground that it violated the "due process" clauses of the federal and state constitutions. I should possibly first mention something about "due process" and "police power." The federal and state governments may not deprive a person of his life, liberty or property without due process of law. However, government does have the power to restrict your rights where it is reasonably related to the public weal. The right of the government to do this is called "police power." Police power of course is not limited to police matters, but covers the enormous range of laws which limit your unlimited freedom of action. I trust few people would quarrel with the right (and necessity) of requiring proper licensure of a physician before he can practice medicine, or placing some limit on the speed of automobiles. However, between these examples and PSRO, you can get into an argument anywhere you go. It is on this principle that the validity of certificate of need turns.

In a North Carolina case[1] the North Carolina Medical Care Commission refused permission for the construction of a 200-bed general hospital which was to be built completely with private funds. The Commission found that this new hospital would spread more thinly already scarce doctors and other personnel and also would result in vacant beds in existing hospitals which would therefore operate less efficiently at a greater cost. The North Carolina Supreme Court voided the North Carolina Certificate of Need law principally on the ground that it violated due process. The Court said that such a restriction, to be valid, must have a "reasonable and substantial relation to the evils it purports to remedy" for the public good. The Court found no reasonable relationship between the right of a private person to build a

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad Street, Atlanta, Ga. 30303.

hospital with his own funds on his own property and the alleged promotion of public health.

A New York Court[2] reached the opposite result. Here the New York authorities refused to permit the construction of a private proprietary nursing home, stating that there was no "public need for the existence" of the facility. The law was challenged as unconstitutional because it was not a "reasonable" exercise of the state's police power. The New York Court decided that the uncontrolled construction of unnecessary nursing homes could be a cause of "spiralling" health care costs. It held that a proliferation of facilities beyond the needs of an area and the resulting increased costs bore a reasonable relationship to the welfare of the community. Therefore this law was a valid exercise of police power.

We have no certificate of need law in Georgia as yet. The legal precedents here in other regulatory matters are about the same as in other states. It has been held by the Georgia Supreme Court that exercise of police power cannot unreasonably invade constitutionally guaranteed rights. However, the state can "reasonably regulate where there is a necessity for the protection of public health, safety and the general welfare." If certificate of need legislation is passed by the General Assembly and is challenged, the Georgia court would have to decide whether this kind of restriction on an otherwise lawful business was reasonably necessary and whether it bore a reasonable relationship to the public good. It is really impossible to predict how the case might come out.

Would Legislation Control Costs

One approach might be to investigate fully whether certificate of need legislation will in fact control costs. If significant health cost control will result, then at least a court would have some reason to say that such a law bears a relationship to public good and public health. However, if no significant cost benefits can be shown then there could hardly be any proper exercise of police power. In the New York case, in a very short opinion, the Judge apparently just assumed that excessive construction caused increased costs. He cited no studies or other information to support this conclusion. The North Carolina Court did not go into the matter of costs, but placed its decision on grounds other than cost factors. In a recent exhaustive article in the *University of Virginia Law Review,* the author concluded that it was unlikely that certificate of need laws would appreciably reduce health facility costs.[3]

It is probable that certificate of need legislation will continue to be pressed. In 1973, regulations of the Secretary of Health, Education and Welfare were issued which require withholding of capital funds assistance under Medicare and certain other federal reimbursement programs unless the facility is approved by a state planning body. About that time a proposal was made, which did not become effective, which would prohibit entirely all types of federal payment and assistance for services in a non-approved facility. If National Health Insurance comes, tougher certificate of need restrictions may well come hand-in-hand.

The present official position of The Medical Association of Georgia is opposed to a certificate of need law for Georgia.

ADDENDUM

After the above article was written, Congress adopted a bill which would require certificate of need legislation in all states. This act has been approved by President Ford. Additional information will be presented later. ■

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I've told this before . . .

(Ed. note: A pompous, long-winded speaker gets a lesson in the value of common sense to explain what the other five senses reveal in this story by J. G. McDaniel, M.D. If you would like to share a favorite story, please send it to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Five Senses

BACK IN THE EARLY '30s a doctor practiced medicine here in Atlanta by the name of O. O. Fanning. Dr. Fanning was a good speaker, quite a wit and philosopher. He had a retentive memory and read a great deal. If there was anything he abhorred it was for some super-scientific doctor to give a long drawn out talk, that, in the opinion of Dr. Fanning, was lacking of good common sense. Should such a paper be delivered in his presence, he would always discuss it, point out the weakness and with subtle wit and humor reduce the speaker to shambles.

We had a doctor speak before our society on physical examinations. Most of his time was spent on inspection. We must look at the patient, said he, get his clothes off, inspect his hair, his ears, his throat, fingernails, his entire body, then look again and again.

Then he went on to explain what could be learned by careful observation. He wound up by saying that other examination was important and quite essential, but he stressed inspection.

I thought it was a good talk, but to me he over-emphasized the focal point of his paper. Several doctors discussed it in an anemic complimentary way.

Gray-haired old Dr. Fanning got up, slowly walked down to the podium, took his unlit cigar from his mouth, cupped his hand over his mouth and coughed.

The best I can remember, he said that God had given us five senses and that one was as important as the others. If we did not or could not use all five of them in any situation, we might make a grave error, or if we came to rely on one sense over all the others, we were in trouble.

At a carnival one night, he said, there was a deaf old farmer standing in front of the show that featured the fat woman, the cigarette fiend, the largest python in the world, the midgets, etc. The barker, through a megaphone, was trying to entice people to come in and see the largest woman in the world. Then he used a pointer to point at her large picture. Then see the largest snake in captivity and as he talked about the snake he pointed to its picture, which happened to be next to the fat lady's picture, and on down the line he went.

People bought tickets and went in, but the old man stood there intently looking at the fat lady and then the snake.

Finally he took his walking stick and beat on the platform. But the barker was busy selling tickets and paid little attention. The old man kept beating, however, and the barker went over and kneeled down. The old farmer put his ear horn in his ear and pointing to the fat lady, asked in a loud voice, "DID I UNDERSTAND YOU TO SAY THAT THAT THERE GIRL PASSED THAT THERE WORM?"

J. G. McDaniel, M.D.,
820 W. Wesley Road, N.W.,
Atlanta, Ga. 30327

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NEW MEMBERS

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Roof, Jack B., Jr. Muscogee—Act—I, R	Medical Center Columbus, Ga. 31902
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Stahlkuppe, Robert F. Muscogee—Act—I, R	Medical Center Columbus, Ga. 31902
Terrell, Joe F. Muscogee—Act—I, R	Medical Center Columbus, Ga. 31902

SOCIETIES

The **Bibb County Medical Society** held a joint meeting in January with the Macon Bar Association.

Ware County's new officers include Robert Packer, president; James Taylor, vice president; Davis Jacobs, secretary; Floyd Davis and S. W. Clarke, delegates to MAG; and W. B. Bates, Jr. and L. C. Durrence, Jr., alternate delegates.

PERSONALS

Third District

John Van Duyn of Columbus is the author of "First Appearance of Lymphedema in Facial Scars" which appeared in the December issue of *Southern Medical Journal.*

Fifth District

MAG President **J. Rhodes Haverty** of Atlanta and **J. G. Etheridge,** president of the Bibb County Medical Society, met with editors of *The Macon Telegraph and News* January 13 for another in a series of conversations with the press. The discussion covered several concerns of organized medicine and was aimed at promoting good lines of communication with the press.

Harold D. Meltzer is the author of an article in the December issue of *Southern Medical Journal* titled "Lymphomatoid Papulosis Eventuating in Mycosis Fungoides." His co-authors are **Robert M. Fine** of Decatur and Earl J. Rudner of Detroit, Mich.

Coordinator of the American Cancer Society Regional Conference on Cancer for Medical Students January 17-18 in Atlanta was **Robert Brown,** professor of surgery at Emory. Other Georgia physicians participating in the program were **A. Hamblin Letton** of Atlanta, past president of the ACS, and **Lois T. Ellison,** associate dean for special programs at the Medical College of Georgia School of Medicine in Augusta.

Seventh District

Harvey Howell of Cartersville is the new president of the medical staff of Sam Howell Memorial Hospital. He will be aided by **W. B. Dillard,** vice president, and Enrique Robles, secretary.

Ninth District

Gainesville physician **R. L. Rogers, Sr.** has been named to the North Georgia College Alumni Association Hall of Fame, being cited for his contributions in medicine and politics. Dr. Rogers served as chairman of the Georgia State Board of Health 18 years and as superintendent of the Hall County Hospital six years. He has been a member of the State Democratic Committee and delegate to the Democratic National Convention.

Tenth District

Cited for service to the field of rehabilitation, **James A. Green** of Athens has been presented the Georgia Rehabilitation Association service award. The Emory Medical School graduate has been on the State Medical Advisory Committee, and for the past 12 years served as medical consultant to the Athens Vocational Rehabilitation office.

Paul G. McDonough, associate professor of obstetrics and gynecology at the Medical College of Georgia, has been named a member of the Reproductive Endocrinology Division of the American Board of Obstetrics and Gynecology. He is one of only 25 physicians in the nation to be so recognized.

DEATHS

James Randall Bryan

Augusta anesthesiologist James Randall Bryan, 51, died December 12, 1974 following a brief illness. Dr. Bryan was graduated from the Medical College of Georgia and was a member of Theta Kappa Psi medical fraternity and Trinity on the Hill United Methodist Church. He was a member of the Richmond County Medical Society.

He is survived by his widow, Mrs. Jackie Harrison Bryan of Augusta; daughters, Deidre Bryan of Gainesville, Fla., Mary Bryan, Liza Bryan, Jenny Bryan and Emily Bryan of Augusta; son, Mike Bryan of Augusta; mother, Mrs. T. R. Bryan of Brooklet; three brothers, Thomas Randall Bryan, III of Jacksonville, Fla., Jack Corson Bryan of Warner Robins and Lucian Bobo Bryan of Lavonia, Mich.; and a sister, Mrs. D. E. Smith of Decatur.

John J. Collins

Pioneer Georgia radiologist, John J. Collins, 77, of Thomasville, died December 28, 1974. Dr. Collins was honored in 1972 by the Georgia House of Representatives with a resolution praising his contribution to the medical profession and his 42 years of service to the people of Thomasville. He had retired from practice three years ago.

Dr. Collins was born in Iowa and was graduated from the University of Iowa. He became interested in radiology while a surgical fellow at the Mayo Clinic in Rochester, Minn. He was the first resident in radiology at Henry Ford Memorial Hospital in Detroit, Mich., working under Dr. Henry T. Doeb. Dr. Collins was one of five radiologists in Georgia when he came to John D. Archbold Memorial Hospital as chief of the Department of Radiology in 1929.

He held professional membership in the American College of Radiology, the Radiologists Society of North America, the American Roentgen Ray Society and attended St. Augustine's Catholic Church.

Survivors include his widow, the former Frances Ryan; daughter, Mrs. Patricia Droste of New York, N.Y.; and son, Dr. J. J. Collins, Jr. of Boston, Mass.

Lawton Quinby Hair

Lifelong Augusta resident Lawton Quinby Hair, 56, died December 14 at his home.

Dr. Hair was a graduate of the University of South Carolina and the Medical College of Georgia. After service in the U.S. Army during World War II, he entered private practice in Augusta in 1951. He was a member of the Georgia Heart Association, the clinical staff of the Medical College of Georgia and past president of the staff of the University Hospital in Augusta.

He is survived by his widow, Mrs. Montine S. Hair, Augusta; daughter, Miss Linda Gail Hair of Falls Church, Va.; sons, Stephen Russell Hair and Barry William Hair of Augusta; brother, W. D. Hair of North Augusta; two sisters, Mrs. C. D. Widener of Augusta and Mrs. R. H. McKenzie of El Paso, Texas.

Decatur internist and cardiologist Benjamin B. Okel, M.D. is sworn in as a member of the Board of Human Resources by outgoing Gov. Jimmy Carter Jan. 14, 1975. Mrs. Deborah Okel and their daughter Susan, 7, attend the ceremonies. Dr. Okel succeeds Corbett H. Turner and will serve until April 1979 in this new position he considers a "challenge." The Tulane University graduate has just completed a year as president of the DeKalb County Medical Society.



John Edward Smith

John Edward Smith, 60, who had practiced in Fitzgerald since 1937, died January 12 following a long illness. Dr. Smith was past chairman of the Board of Stewards for Central United Methodist Church, past president of the Fitzgerald Rotary Club and Fitzgerald Country Club and a former member of the Board of Education. He served as city health officer several years and was director of the First State Bank of Fitzgerald.

Survivors include his widow, Mrs. Margaret W. Smith of Fitzgerald; son, John Edward Smith, III; daughters, Mrs. Margaret Smith Patmon and Miss Mary Beth Smith, all of Fitzgerald; brother, T. Lloyd Smith of Thompson; and a sister, Mrs. Quincy Gilliland of Fitzgerald.

HIGHLIGHTS OF EXECUTIVE COMMITTEE

Saturday, January 11, 1975

Community Based Cancer Control Proposal: Reviewed the proposal of the Cancer Management Network, Inc. and disapproved its submission to the National Cancer Institute as written.

Georgia Hospital Association: Agreed to work with the GHA in planning and inducting educational programs in quality assurance, utilization review, medical audit and related subjects.

Georgia Regional Medical Program Phase Out: Received the report that GRMP probably will remain at present staffing level through 1975, followed by a sharp reduction in staffing level until its completion in June 1976.

Joint MAG-GNHA Commission to Accredit Nursing Homes: Approved a proposal to approach the Georgia Nursing Home Association to determine its interest in forming a committee to accredit nursing homes.

Committee on Access to Health Care: Appointed this committee to be the advisory committee for the physician manpower study.

Chiropractic College: Received the report that a chiropractic college is being established in Marietta.

Certificate of Need: Appointed W. Daniel Jordan, M.D. to meet with legislators on the Georgia Hospital Association and Georgia Nursing Home Association to develop a bill acceptable to MAG.

HIGHLIGHTS OF COUNCIL

Saturday, January 11, 1975 and Sunday, January 12, 1975

SAMA Representatives Expenses: Approved a sum of $600 to reimburse SAMA representatives that attended the SAMA regional meeting in Miami. Maximum reimbursible to each individual to be $60.

Pilot CHEC Program: Approved 12 month interest-free loan to GMCF of $3,000 for the purpose of a pilot CHEC type Concurrent Review Program for implementation in four hospitals.

Georgia Council for Family Practice Education: Approved a request from this group for $700 to subsidize the publication and distribution of a booklet entitled "The Need for More Family Doctors."

MAG Newsletter: Approved the expenditure of $840 over the next four months. An additional $250 will come from Roche Laboratories for the publication of the Newsletter.

MAG Headquarters Roof: Approved the expenditure of $9,380 for the replacement of the leaking roof.

Non-Aligned County Medical Societies: Approved the alignment of Bryan, Baker and Dawson Counties with the largest county medical society adjacent to each. Bryan with Georgia Medical Society, Baker with Dougherty Medical Society, and Dawson with Hall County Medical Society. Each medical society had previously agreed to accept these counties.

Stephens County Medical Society: Approved a change in name to Stephens-Rabun County Medical Society.

PSROG: Approved a recommendation of the Executive Committee to hold a referendum of the entire membership in the question of whether or not MAG or its designee should apply for a single statewide PSRO designation. The report of the poll will be given to the House of Delegates in April.

Degree Designations for Foreign Medical Graduates: Received a recommendation of this committee that only two degree designations be used by Georgia physicians—M.D. and D.O.—and directed that this recommendation be transmitted to the Composite State Board of Medical Examiners.

Research and Development: Approved an R & D section for MAG and referred the proposed budget to the Finance Committee for study and further reference to the House of Delegates in April.

Georgia Medical Care Foundation: Voted to direct the GMCF Board of Directors to explore the possibility of taking over the entire Medicaid program in Georgia. Received a report that the GMCF is interested in contracting with Medicaid on the New Drug Review Program.

Cancer Programs: Received a report that the Executive Committee, on the previous day, had voted to advise the Cancer Management Network, Inc. of MAG's opposition to the submission to NCI of their proposal for the Community Based Cancer Control Program. MAG staff was directed to proceed with the submission of the SEER Program.

Concurrent Hospital Care Review: Agreed to request the Secretary of HEW to extend the deadline for the new UR regulations 12 months; agreed to advise Blue Cross that the Model UR Plan appears to comply with new regulations but the criteria do not reflect the realities of medical practice and should not be distributed. Suggested to Blue Cross to encourage hospitals medical staff development of UR plans and criteria based on CHEC; approved the report of the Ad Hoc Committee on Concurrent Hospital Review outlining the role of GMCF in the concurrent review process.

Date and Site of Next Meeting: April 17 at the Fairmont Colony Square Hotel in conjunction with the Annual Session.

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Also

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OFFICE OF PUBLICATION
The Ovid Bell Press, Inc.
1201-05 Bluff Street
Fulton, Missouri 65251

Second Class postage paid at Fulton, Missouri.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1975, Medical Association of Georgia.

Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

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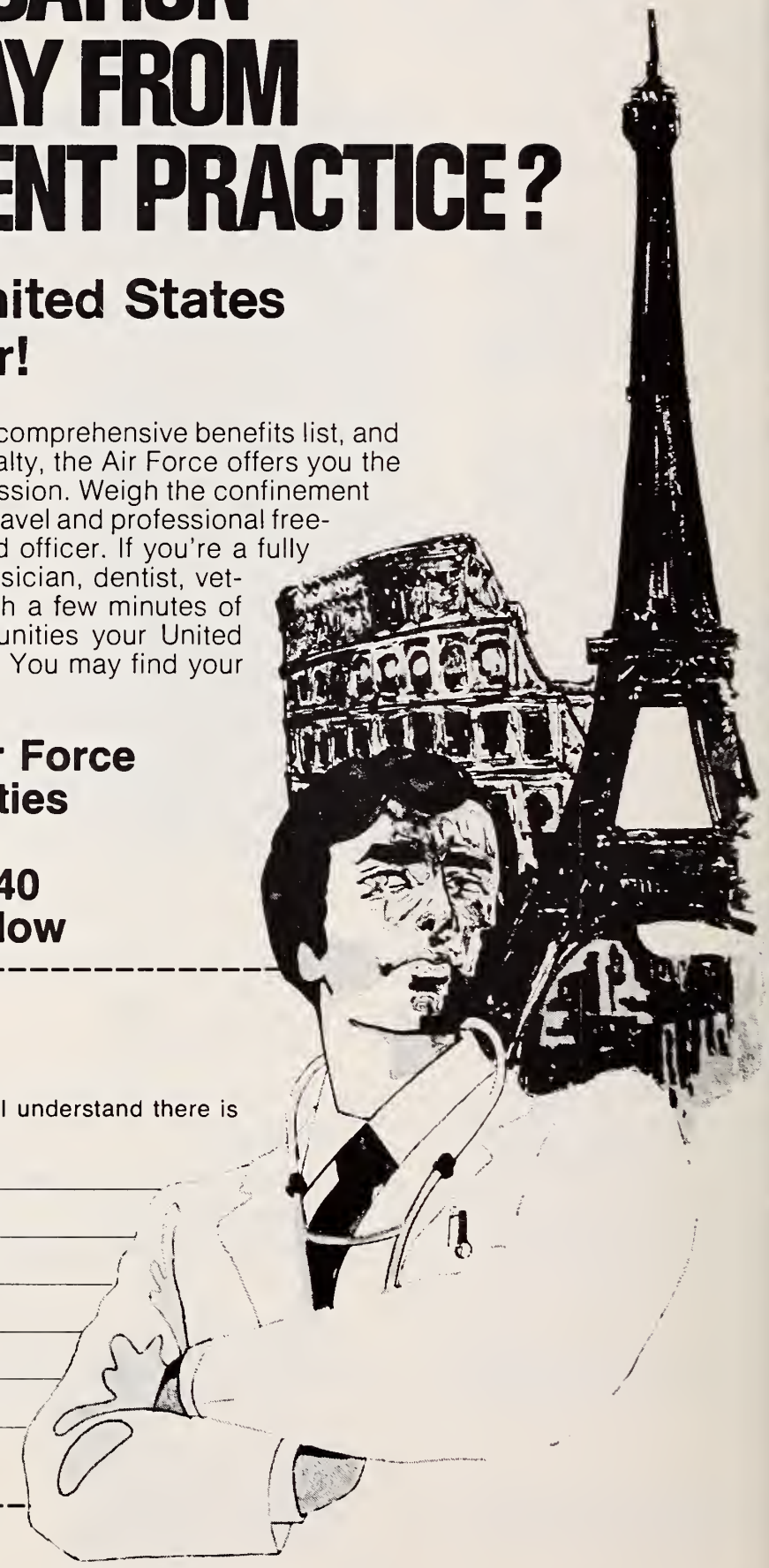
THE COVER

Several articles explaining new federal regulations affecting the practice of medicine are offered in the March *Journal*. Layout by Bob Hamill.

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Summary of the National Health Planning and Resources Development Act of 1974

J. GORDON BARROW, M.D. *and* ROBERT A. YOUNGERMAN, J.D., *Atlanta**

PL 93-641 WAS SIGNED into law by President Ford on January 4, 1975.

The legislation, according to House Report No. 93-1382 of the Committee on Interstate and Foreign Commerce, attempts to combine the best features of Comprehensive Health Planning agencies (CHP), Regional Medical Programs (RMP), and Hill-Burton agencies, "into one new health planning and resources development effort." The functions at which the legislation is directed are (1) health planning, heretofore provided through CHP; (2) development of health resources, heretofore provided through RMPs (for health services) and Hill-Burton agencies (for health facilities); and (3) regulation or quasi-regulation such as certificate of need for hospital beds and Section 1122 of the Social Security Act which provides for review of capital expenditures for hospital construction, both of which have been accomplished through CHP agencies depending on state law.

OUTLINE OF THE MAJOR PROVISIONS

The legislation provides for two new titles to be added to the Public Health Service Act. Title XV is on National Health Planning and Development, and Title XVI is on Health Resources Development. Title XV has three principal parts: Part A—National Guidelines for Health Planning; Part B—Health Systems Agencies; and Part C—State Health Planning and Development. Title XVI can be divided into two principal parts, one on medical facilities construction and the other on area health services development. The existing agencies, CHP, RMP and Hill-Burton, would continue under the new law until June 30, 1976 or three months following the designation of health systems agencies (HSA), whichever is later.

Title XV

PART A of the new title XV requires the Secretary to issue, by regulation, guidelines concerning national health planning policy within 18 months of enactment. These guidelines are to include a statement of national health planning goals based upon national health priorities specified in the legislation. In issuing the guidelines the Secretary is to consult with the health systems agencies, the state health planning and development agencies, the Statewide Health Coordinating Councils, the National Council on Health Planning and Development established by this Act, and associations and specialty societies representing medical and other health care providers.

PART B of the new title XV creates a network of health systems agencies responsible for health planning and development throughout the country. In creating such a network, the governors of the states would be asked to designate throughout the country health service areas for planning and development purposes which meet the requirements specified in the legislation. These requirements are as follows:

1. The area must be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availabili-

* Dr. Barrow serves as coordinator of the Georgia Regional Medical Program, 938 Peachtree St., N.E., Atlanta, Ga. 30309. Mr. Youngerman is the coordinator of Inter-Regional Programs, of the Southeastern Regional Medical Programs.

ty of resources to provide all necessary health services for residents of the area.

2. To the extent practicable, the area must include at least one center for the provision of highly specialized health services.

3. Each area must have a population of not less than 500,000 or more than three million, except that an area may be less than 500,000 if the area comprises an entire state with a population of less than 500,000 or more than three million if the area includes a standard metropolitan statistical area with a greater population.

The legislation also permits the area to be less than 500,000 to a minimum of 200,000 under "unusual circumstances" and below 200,000 in "highly unusual circumstances," both as determined by the Secretary.

4. The area boundaries, to the maximum extent feasible, must be appropriately coordinated with those of Professional Standards Review Organizations, existing regional planning areas, and state planning and administrative areas.

5. The boundaries are also to be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. Determination of boundaries are to reflect the differences in health planning and health services development needs between metropolitan and nonmetropolitan areas.

6. Each standard metropolitan statistical area (SMSA) must be entirely within the boundaries of a single health service area. This requirement may be waived if a governor determines, with the approval of the Secretary, that in order to meet the above-mentioned requirements, a health service area may contain only part of the SMSA.

The legislation further provides that the Secretary must designate as health service areas those areas now served by agencies funded under section 314(b) if they meet all the requirements listed above unless the governor determines that other areas are more appropriate. The Act also provides that no areas need be designated for states which have no county or municipal public health institution or department and which have maintained a health planning system which complies with the purposes of this title.

The Secretary may revise the governors' designations only where they are inconsistent with the above-mentioned requirements. The Secretary is responsible for publishing the health service area boundary designations in the Federal Register within seven months of enactment.

In each health service area, the Secretary, after consulting with the governor of the appropriate state, must then designate either a private nonprofit corporation or a public entity as the health systems agency responsible for health planning and development in that area. A health systems agency may not be or operate an educational institution. The legislation specifies minimum criteria for the legal structure, staff, governing body, and functioning of the health systems agencies. They would be generally responsible for preparing and implementing plans designed to improve the health of the residents of their health service area; to increase the accessibility, acceptability, continuity, and quality of health services in the area; to restrain increases in the cost of providing health services; and to prevent unnecessary duplication of health resources. In performing these responsibilities, the health systems agencies are required to:

- gather and analyze suitable data;
- establish health systems plans (goals) and annual implementation plans (objectives and priorities);
- provide either technical and/or limited financial assistance to people seeking to implement provisions of the plans;
- coordinate activities with PSROs and other appropriate planning and regulatory entities;
- review and approve or disapprove applications for federal funds for health programs within the area;
- assist states in the performance of capital expenditure reviews;
- assist states in making findings as to the need for new institutional health services proposed to be offered in the area;
- assist states in reviewing existing institutional health services offered with respect to the appropriateness of such services; and
- annually recommend to states projects for the modernization, construction, and conversion of medical facilities in the area.

PART C requires the Secretary to designate an agency of state government chosen by the governor in each state to serve as the state health planning and development agency (state agency). In order to be designated, the state agency must prepare and submit to the Secretary for approval an administrative program for carrying out its functions. The state agency is to be advised by a Statewide Health Coordinating Council whose composition and responsibilities are specified in the legislation including requirements that the Council:

• have 60 per cent of its members appointed by the Governor from the state's health systems agencies and have a consumer majority;

• review annually and coordinate the health systems plans and annual implementation plans of the state's health systems agencies and make comments to the Secretary;

• prepare a state health plan made up of the health systems plans of the health systems agencies, taking into account the preliminary plan developed by the state agency;

• review for the Secretary budgets and applications for assistance of health systems agencies;

• advise the state agency on the performance of its functions; and

• review and approve or disapprove state plans and applications for health-type formula grants to the state.

The required functions of the state agency are specified and include:

• conducting the state's health planning activities and implementing the parts of the state health plan and plans for health systems agencies which relate to the government of the state;

• preparing a preliminary state plan for approval or disapproval by the Council;

• assisting the Council in the review of the state medical facilities plan and in the performance of its functions;

• serving as the designated planning agency under Section 1122 of the Social Security Act if the state had made an agreement and administering a state certificate of need program of comparable scope;

• reviewing new institutional health services proposed and making findings as to the need for such services; and

• reviewing existing institutional health services offered with respect to the appropriateness of such services and making public its findings.

Any of the functions described above may be performed by another agency of state government upon the request of the Governor under an agreement with the state agency satisfactory to the Secretary.

Part C also provides that the Secretary may make grants for the purpose of demonstrating the effectiveness of rate regulation to a maximum of six states who are regulating, or have indicated their intent to regulate, rates prior to the end of six months after the date of enactment.

PART D contains general provisions applicable to the above programs. These include:

• procedures and criteria for use by the health systems agencies and the state agencies in performing the reviews required by the Act;

• requirements that the Secretary provide technical assistance to health systems agencies and state agencies and establish a national health planning information center;

• a requirement that the Secretary fund at least five centers for the study and development of health planning; and

• requirements that the Secretary review and approve or disapprove the annual budgets of each health systems agency and state agency, develop performance standards for health systems agencies and state agencies and monitor their performance, and review in detail at least every three years the structure, operation, and performance of each health systems agency and state agency.

Title XVI

Parts A, B, C, D, and E of the new title XVI revise the existing medical facilities construction program and relate their activities more closely than is presently the case to the planning programs created by new title XV. Part F provides development funds for each health systems agency to enable the agency to establish and maintain an Area Health Services Development Fund.

PART A sets forth the general purposes of title XVI which is to provide assistance, through allotments under Part B and loans and loan guarantees and interest subsidies under Part C, for projects for:

1. modernization of medical facilities;
2. construction of new outpatient medical facilities;
3. construction of new inpatient medical facilities in areas which have experienced recent rapid population growth (as defined in regulations of the Secretary); and
4. conversion of existing medical facilities for the provision of new health services.

It is also the purpose to provide grant assistance for construction and modernization projects designed to eliminate or prevent safety hazards or avoid noncompliance with licensure or accreditation standards.

As a condition to the receipt of funds under Parts B and C, a state agency must have approved by the Secretary a state medical facilities plan. Prior to the Secretary's approval, the plan must be approved by the Statewide Health Coordinating Council in terms of its consistency with the state health plan.

The facilities plan is to include a list of the projects for which assistance will be sought and the priorities for funding of these projects. For each project, an application must be submitted to the Secretary for approval and it must set forth a number of assurances including one that services in assisted facilities will be made available to all persons residing

or employed in the areas served by the facilities and that a reasonable volume of services will be available to persons unable to pay.

PART B provides for allotments to the states on the basis of population, financial need, and the need for medical facilities projects. Not more than 20 per cent of a state's allotment may be used for projects for construction of new inpatient facilities in areas which have experienced recent rapid population growth and not less than 25 per cent may be used for projects for outpatient facilities which will serve medically underserved populations, half of which must be expended in rural medically underserved areas.

In the case of a project to be assisted under an allotment, the federal share may not exceed two-thirds of the costs except that a project in a rural or urban poverty area may receive 100 per cent federal funding.

This part also directs the Secretary to review compliance with the assurances made under Title VI and to those made under the new program. If the Secretary finds that an entity has failed to comply with assurances, he must either withhold payments to the entity or effect compliance by other means authorized by existing law including bringing suit in federal court. Actions to enforce compliance may be brought by a person other than the Secretary, if the Secretary has either dismissed a complaint made to him by such person or has failed to act on such complaint within six months after the date on which it was filed with him.

PART C authorizes the Secretary to make loans and guarantee loans to nonfederal lenders and the Federal Financing Bank for medical facilities projects. A loan or loan guarantee may not exceed 90 per cent of the costs of a project unless the project is in an urban or rural poverty area, in which case the loan or loan guarantee may cover 100 per cent of the costs.

PART D provides for direct federal project grants to publicly owned health facilities for construction or modernization projects designed to eliminate or prevent safety hazards or avoid noncompliance with state or voluntary licensure or accreditation standards. The amount of any grant may not exceed 75 per cent of the project costs unless the project is located in an urban or rural poverty area in which case the grant may cover 100 per cent of the costs. Of the funds appropriated for allotment to the states, 22 per cent must be made available for project grants.

PART E contains general provisions pertaining to judicial review, recovery, state control of operations, definitions, financial statements, and technical assistance.

PART F relates to the Area Health Services Development Funds and authorizes the Secretary to make development grants to each health systems agency which has a designation agreement in effect, has plans in effect reviewed by the Statewide Health Coordinating Council, and is organized, operated, and performing its functions in a manner satisfactory to the Secretary. A development grant may not exceed $1 per person in the health service area.

Finally, the legislation includes several transitional provisions. Appropriations are authorized through fiscal year 1976 for 314(a) and (b) agencies, regional medical programs, and experimental health service delivery systems. These funds will be available for three months after a new agency is designated for a state or area or June 30, 1976, whichever is later. A state which has funds available through fiscal year 1976 from its allotments under Part A of Title VI may use 4 per cent or $100,000 whichever is less for the administration of its approved state plan. ■

SECOND MEMORIAL LECTURESHIP HELD AT GRADY

The second annual Renee Tanger Lowenberg Memorial Lectureship will be held at 12 noon, Thursday, March 27 at Grady Memorial Hospital Auditorium for combined Medical-Surgical Rounds. The guest speaker will be Dr. Edward Coppola, professor and chairman of the Department of Surgery, Michigan State University School of Medicine. The title of Dr. Coppola's address will be "Review of Renal Transplantation."

Utilization Review: The Revised Regulations

(Ed. note: The following is a summary of Medicare and Medicaid revised regulations on utilization review—the conditions of participation for hospitals and nursing facilities. Originally these regulations would have become effective Feb. 1, 1975, but more recent communication from the Department of Health, Education and Welfare calls for an April 1 implementation date.)

Revised utilization review plan of hospitals must provide for admission certification for elective admissions, extended stay review and medical evaluation studies. Objective of these activities is assurance of high quality patient care, effective and efficient utilization of the hospital and its services. These functions *may* be performed by a staff committee of the hospital—at least two physicians and other professional personnel. Final decisions on admission or continued stay are made by at least two physician members of the committee. The review must be based on written criteria and standards developed by or selected by the committee. A hospital may request an extension of the February 1 deadline (see Ed. note) from DHEW in order to select or develop the criteria and standards.

Admission review will be performed within *one* working day after elective or emergency admission. Data upon which the certification is based must include: diagnosis or symptoms; plan of treatment; where applicable, date of operating room reservation; other appropriate supporting information—test results, history, etc.—as deemed necessary by the committee; emergency admission must be justified in writing. Pre-admission review is permitted, especially for elective admissions which will involve unusually high cost, are often of questionable necessity or are proposed by physicians with questionable patterns of practice. For admissions deemed not medically necessary, notice of final determination must be given within 48 hours of admission. For certified admissions, an extended stay review date is set based on the 50th percentile of regional LOS norms.

Extended stay review begins prior to or on the review date assigned. The review is based on the attending physician's plan for continued stay and justification as well as other information deemed necessary by the committee. A new review date may be assigned if continued stay is medically necessary. If continued stay is not medically necessary, written notice must be provided no later than *two* working days after the certification date.

Medical care evaluation studies must be in progress at any given time and at least one per year must be completed. Studies will be based on consideration and analysis of data from: medical records; data from external organizations—CHIP, EMCRO, etc.; cooperative efforts with a PSRO, fiscal intermediaries, providers or others. The purpose of the studies is to promote effective and efficient use of available hospital facilities and services. Studies must include data on: admissions, duration of stay, ancillary services and professional services.

The new UR requirements for a skilled nursing facility include similar admission certification, extended stay review, and medical care evaluation study standards. An additional standard for skilled nursing facilities is for operation of a discharge planning program.

The imposition of any of these requirements on Title XIX may be waived by the Secretary if the Secretary can be satisfied that existing Title XIX review activities are superior in their effectiveness. After at least one year of operation but no more than two years of the Title XIX UR activities, the Secretary may extend them to Title XVIII if it is determined that the Title XIX review is superior to the Title XVIII review in its effectiveness.

Concurrent Review and the CHEC Program

C. E. BOHLER, M.D., *Brooklet**

On November 29, 1974, the federal government issued the final version of new utilization review regulations designed to enforce the implementation of concurrent admission and utilization review requirements for acute hospital patients beginning February 1, 1975. This date has subsequently been extended to at least April 1, 1975, but is still far short of any reasonable period of time that might actually be required.

Physician-Controlled System

The Georgia Medical Care Foundation in August 1973, in anticipation of these UR regulations and the requirements of PSRO, and out of a desire to eliminate the inherent inequities of retrospective review and retroactive denial, began developing a physician-controlled concurrent hospital review system capable of satisfying all of the utilization and admission review requirements anticipated in the laws we are now seeing. The resulting program is called CHEC (for Certified Hospital Extension of Care) and it does satisfy the requirements of the regulations as we now know them, while maintaining medical control over the entire monitoring process. The program is simple, straightforward, and centered within the hospital staff, and I would like to outline it for you briefly.

The CHEC program utilizes a utilization review coordinator in the participating hospital to perform the required day-to-day monitoring and reporting functions including assigning of initial review dates, monitoring patient progress, and certification of claims of payment. (The UR coordinator may be a nurse, ex-military corpsman, or other similarly qualified health care professional.)

Role of the Physician Advisor

The physician advisor is a staff physician and a member of the hospital's UR committee, and is responsible to the Foundation for the medical direction of the program in the facility in which he functions. He makes all medical decisions related to the program and whenever a question requiring professional medical judgement arises, the coordinator *must* refer the matter to the physician advisor for resolution. Where the attending physician and the physician advisor disagree, the case is immediately appealed to each facility's utilization review committee. Subsequent appeals are handled through the Foundation/MAG review process.

Foundation monitoring of the review system is exercised in several ways through the use of data collected on a data input form completed by the coordinator for each patient at the time of discharge. This data will be used to assure that the CHEC program is functioning well in all areas. Foundation physicians and members of the GMCF staff will make regular visits to the hospitals involved in the CHEC program to provide assistance in program administrative areas and to discuss problems of program operation.

The CHEC program operating within a hospital allows decisions concerning medical appropriateness to be made within the hospital by a physician advisor and, when necessary, the utilization review committee, and prevents these cases from being subjected to retrospective review and denial except in cases where the hospital is found to be in noncompliance with the program.

The overall effect of the CHEC program will be to reduce unnecessary services and days of stay being delivered by creating physician awareness of length-of-stay experience observed throughout the state. It will also eliminate the false savings currently observed under retrospective review and denial by assuring that the services delivered are medically appropriate.

The CHEC program is currently operating in four Georgia hospitals on a pilot basis funded jointly by MAG and the Department of Human Resources. Physician and administration acceptance is very high, and expansion to operation on a statewide basis is anticipated in the near future. ■

* Box 8, Brooklet, Ga. 30415. Dr. Bohler, immediate past president of MAG, serves as president of the Georgia Medical Care Foundation and Chairman of its Board of Directors.

The CHEC Program and How It Functions

The following article is a fair and reasonable explanation of the operation of the GMCF's CHEC Program. I believe it to be the best method available to us as physicians for complying with the utilization review requirements recently mandated under Titles XVIII and XIX.

These regulations are already upon us, and they demand immediate compliance. It must be pointed out that as yet HEW has not agreed that the CHEC program without modification will satisfy the regulations as MAG has requested. Given this fact, and the pressures sure to arise shortly from other third-party payors for similar review for all patients, it is obvious that the Medical Association of Georgia and its Medical Care Foundation must maintain control of the utilization review process and assure that medical appropriateness and medical necessity, rather than pure costs, are the determinants employed in reviewing medical care. The CHEC Program is our means to that end.

L. C. Buchanan, M.D., Treasurer
Georgia Medical Care Foundation

THE CHEC PROGRAM IS a concurrent in-hospital admission and utilization review program intended to assure the delivery of high quality medical care to the people of Georgia. The program is designed to protect the right of patients, hospitals, and physicians by placing the responsibility for decisions relating to appropriateness and necessity of in-hospital medical care where it properly belongs, on the medical community. This provides creditability to the medical profession and increases assurances that peer review will remain in the hands of medical professionals.

In each participating hospital one or more utilization review coordinators are used. These coordinators at this time review all patients admitted to the hospital who are covered by Medicaid. Physician advisor(s), usually members of the participating hospital's medical staff and utilization review committee, have responsibility for making all medical decisions regarding medical necessity of admissions and continued stay.

The coordinator reviews the chart of each new admission on the admission day or the first working day following admission with particular attention to admitting diagnosis, history and physical examination report, and physician's orders. Based upon the chart findings, and if there are no questions of necessity of admission, (s)he assigns from the length-of-stay criteria the appropriate initial extended stay review date. The existence of multiple diagnoses is taken into account in length-of-stay determination. Initial certification for length-of-stay will be based upon specific Georgia experience for any diagnostic set or operative procedure. As additional information is accumulated in Georgia the length-of-stay criteria will be modified as indicated by CHEC operating experience.

The certified length-of-stay is recorded on a CHEC certification sticker, which is attached to the patient's chart so as to alert the attending physician as to the initially certified number of days. The initially certified length-of-stay is not a maximum number of days allowed to a patient, but rather a guideline for the timing of further reviews of medical necessity.

In the event there is any difficulty in determining the length-of-stay from available information, the coordinator will obtain the assistance of the physician advisor. The physician advisor may deny certification, if after reasonable evaluation of the information submitted, and after discussing the case with the attending physician, he feels that hospital confinement is not necessary. When such a determination is made, the hospital and the attending physician will be notified immediately that benefit payment for continued confinement will not be available.

The coordinator is responsible for regular monitoring of appropriate patient records in each hospital and for securing diagnoses in emergency cases to determine initial length-of-stay. During this monitoring, the coordinator notes changes in diagnosis and recertifies for appropriate length-of-stay as indicated by changes in diagnosis. However, this certification may not be for less than the number of days that the patient already has been hospitalized.

The coordinator will review the chart of each patient two days prior to the expiration of initial certification and place in the chart a "2 Day Notice" (request for extension) for the attending physician.

If the patient is to be discharged by the expiration of certification, no further action is required of the attending physician. If, however, he feels that the patient needs more time, he completes the request for extension, giving pertinent medical justification for more days and the number of days requested.

CHEC / Continued

If the medical data supplied by the attending physician, or the request for extension, does not clearly show the need for an extension, the coordinator will refer the case to the physician advisor, who may talk to the attending physician before making a decision.

On those cases in which the need for an additional stay is obvious, the coordinator may grant an extension without contacting the physician advisor.

Termination of certification by CHEC is not an order to discharge the patient from the hospital. It merely informs all parties—the attending physician, the patient, the hospital, and Medicaid—that CHEC (i.e. the hospital medical staff) is unable medically to justify the patient's continued stay in the hospital.

In case of denial, the attending physician may request immediate review by the designated appeals panel of the hospital utilization review committee.

If an extension request is denied and the physician appeals the decision, Medicaid will be responsible for payment of hospital benefits up to and including the date determined by the first level of appeal to be the date benefits should have been discontinued.

Under CHEC, no presumption is made or implied with respect to eligibility for coverage or appropriateness of daily service charges. Hospitals are guaranteed payment for days of care certified by CHEC only if the patient is otherwise eligible for coverage. ■

CME ACCREDITATION SOUGHT BY GEORGIA ORGANIZATIONS



Ayten Someren, M.D. (center) accepts a certificate of accreditation as president of the Atlanta Society of Pathologists from Stephen Daniel (L), MAG staff and Nicholas Davies, M.D., chairman of MAG's Education Committee.

January was an eventful month for the recognition of continuing medical education programs in the state. January 8 Nicholas Davies, M.D. and Stephen Daniel, representing the Medical Association of Georgia, presented AMA's certificate of accreditation to the Atlanta Society of Pathologists at its monthly educational meeting. January 28, Dr. Daniel traveled to Columbus, where the certificate of accreditation went to Daniel Cabiniss, M.D. for the Medical Center of Columbus. During the trip Dr. Daniel spoke to members of the Muscogee County Medical Society concerning MAG's educational program.

The presentation of an accreditation certificate to the Atlanta Graduate Medical Assembly will bring to four the number of accredited CME programs in the state. MAG is awaiting AMA certificates for two additional organizations, the Medical Center of Central Georgia in Macon and the Southeastern Angiographic Society, and recently conducted an accreditation site survey of Northside Hospital in Atlanta. Ten more hospitals and medical organizations have requested and received materials from MAG to prepare themselves for accreditation surveys. Thus, in little more than a year, MAG has moved to the forefront in the encouragement and recognition of continuing medical education programs.

This operation has definite therapeutic benefits and now can be performed by the relatively simple and complete procedure of transsphenoidal hypophysectomy.

Hypophysectomy in the Treatment of Disseminated Carcinoma of the Breast and Prostate Gland

GEORGE T. TINDALL, M.D., SAMUEL S. AMBROSE, M.D. *and*
JAMES H. CHRISTY, M.D., *Atlanta**

THE VALUE OF HYPOPHYSECTOMY as a gratifying palliative operation in the management of metastatic cancer of the breast[1, 2–4, 10–12, 19–21, 24] and prostate gland[5, 13, 17, 22, 24 27] is well established. Since the introduction of this procedure by Luft and Olivecrona[12] in 1953, several other authoritative reports documenting its value have been published. Initially, a formal craniotomy was necessary to perform hypophysectomy and while definite therapeutic benefits were obtained, some clinicians believed that this operative approach was too extensive for many patients with advanced breast and prostatic cancer.

Fortunately, recent refinements in the operative technique of hypophysectomy, particularly the introduction of the open transsphenoidal microsurgical technique for total pituitary ablation, have resulted in an operative procedure which is considerably less disturbing to a patient than an intracranial operation.[8, 10] Thus, transsphenoidal hypophysectomy can now be offered to patients who would otherwise not be good risk candidates for craniotomy.

In this publication the indications for and results of hypophysectomy for advanced breast and prostate gland cancer will be reviewed. In addition, the technique of open microsurgical transsphenoidal hypophysectomy will be described briefly.

Advanced Breast Cancer

Hypophysectomy can be recommended for most patients with widespread and advancing cancer of the breast, whose recurrent disease is not suitable for either local excision or radiation therapy. In premenopausal patients, oophorectomy should be carried out and evaluated as the initial palliative procedure. However, an oophorectomy failure should not be considered a contraindication to hypophysectomy. In postmenopausal patients, the effects of androgen/estrogen therapy should be evaluated before performing hypophysectomy.

Hypophysectomy should be considered relatively early in the course of breast cancer because when this procedure is carried out only as a last resort or after extensive chemotherapy, radiation therapy and/or adrenalectomy have been employed, relatively poor results in terms of a useful remission can be expected.

Hypophysectomy should not be performed in debilitated patients who are poor anesthetic risks or in those who are unlikely to follow instructions regarding postoperative replacement therapy or who will not avail themselves of the necessary follow-up medical supervision.

Other Factors Influencing Remission in Breast Cancer

1. Age. The results of several studies indicate that the incidence of remission in premenopausal women, particularly those women under 40 years of age, has been slightly lower than the general average, while in older women, *i.e.*, 60 to 75 years, the remission rate has been higher.[3, 4, 21]

2. Previous response to oophorectomy and hormone therapy. Authorities agree that the most reliable index for predicting a satisfactory remission from hypophysectomy is a previous favorable response to oophorectomy in the premenopausal patient.[3, 11, 19] Pearson and Ray[19] contend that ap-

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proximately 90 per cent of the patients who have shown remission following oophorectomy will obtain objective improvement from hypophysectomy. Conway and Collins[3] noted similar results in their series of 100 cases, obtaining remission in 86 per cent of this group of patients.

Likewise, the response to androgen and/or estrogen therapy is useful in predicting the response to hypophysectomy.[3, 11] Kennedy and French[11] found that 14 of 20 (70 per cent) postmenopausal women who had exhibited a favorable response to hormonal therapy had an improvement after hypophysectomy.

The selection of patients for hypophysectomy should not be restricted to those patients who have shown a previous remission to oophorectomy or an appropriate response to androgen/estrogen treatment. The data of Conway and Collins[3] is significant in this regard. In a series of 100 patients, they found that 25 per cent of women who failed to respond favorably to oophorectomy subsequently obtained a satisfactory remission following hypophysectomy. Also, these workers found that 24 per cent of women who failed to respond to androgen/estrogen therapy later obtained a remission from hypophysectomy. These findings indicate that if hypophysectomy is limited only to those patients who show remission from castration and/or androgen/estrogen treatment, then a significant number of patients (*i.e.,* 25 per cent) will be denied the benefits of hypophysectomy.

3. Site of metastases. While most authorities agree that the best response is obtained in patients with bony metastases,[10, 14] patients with visceral metastases can also be considered for hypophysectomy. Contrary to popular belief, the presence of liver metastases does not indicate a poor response to hypophysectomy. It is significant that in Conway and Collins' series,[3] 37 per cent of 30 patients with liver metastases obtained a remission following pituitary ablation.

Advanced Cancer of the Prostate

There is evidence that the majority of patients with disseminated prostatic cancer obtain a gratifying remission following hypophysectomy.[5, 13, 17, 22, 24, 27] It is significant that the group obtaining a response includes many patients who previously failed to respond to orchiectomy and/or a course of estrogen therapy.[5, 13, 22] For this reason, hypophysectomy could be recommended in all patients with proven progressive prostatic cancer who have undergone orchiectomy and a course of estrogen therapy regardless of the initial response to the latters forms of treatment.

Advanced age alone is not a contraindictation of hypophysectomy. In this regard, it is noteworthy that Fergusson and Phillips[5] obtained remission in 14, or 66 per cent, of 21 patients over the age of 70 years following hypophysectomy. As in breast cancer patients, hypophysectomy should not be performed in subjects who are poor operative risks and who are unreliable from the standpoint of taking replacement medications or who will not avail themselves of the necessary follow-up medical supervision.

Endocrinological Evaluation

In order to assess the completeness of pituitary ablation and its effects on trophic and target organ hormone production, a series of preoperative and postoperative studies which will reflect functions of the pituitary-target organ axis should be obtained. While numerous investigations are available for this purpose, one should select only those studies that reflect production of gonadotropin (serum FSH, LH, testosterone and estradiol), somatotropin reserve (serum fasting growth hormone followed by glucagon stimulation[15, 28] with repeat growth hormone at 120 and 180 minutes after glucagon 1 mg intramuscularly), prolactin reserve (thyrotropin releasing factor or chlorpromazine stimulation[25, 26]), thyrotropin (serum TSH and free T_4 preferably based upon competitive protein binding method[16]), adrenocorticotropin (early morning serum cortisol; 24 hour urine 17-hydroxy and 17-ketosteroids) and vasopressin (stimultaneous serum and urine osmolality after minimal fasting period of eight hours). The determination of prolactin reserve will probably be of greater importance in evaluating the effects of pituitary ablation in patients with metastatic breast cancer than those with disseminated prostatic cancer.

Technique of Hypophysectomy

Because of the completeness of ablation and relative safety of the operation, many neurosurgeons now consider open microsurgical transsphenoidal hypophysectomy to be the procedure of choice in patients with advanced cancer of the prostate and breast.[2, 8]

The important steps of this operative technique which is performed using general anesthesia are illustrated and described in Figures 1 to 3. A small incision is made in the upper gingival margin and a submucosal dissection plane is developed along each side of the nasal septum. The septum is excised and the anterior wall of the sphenoid sinus (vomer) is removed. Using fluoroscopic control (image intensifier) the limits of the floor of the sella turcica are identified. The operating microscope is then brought into the surgical field and the remainder of

the operation is performed using magnification. The sella floor is removed following which the pituitary gland is totally excised using instruments specially designed for this purpose.

Closure of the operative wound is simple and involves only a single layer of interrupted absorbable suture in the gingival margin. Each nostril is gently packed with strips of vaseline gauze for two days in order to reattach the nasal mucosa.

Postoperative Management

In the immediate postoperative period, the primary concerns are adequate corticosteroid coverage and fluid balance. Corticosteroids are given at appropriate time intervals and fluid balance must be followed by strict attention to hourly fluid intake and output and urine specific gravity. A constant alert for the ever present possibility of postsurgical diabetes insipidus must be maintained, as it can occur abruptly (a few hours) or insidiously (several days). Hydrocortisone is administered intramuscularly in a dosage of 50 mg every 8 hours for the first two days and every 12 hours for the third day following surgery. For the remainder of the patient's hospital stay, hydrocortisone is administered orally in a dosage of 20 mg every 12 hours.

In most cases, postoperative diabetes insipidus is either transitory, terminating by the time the patient

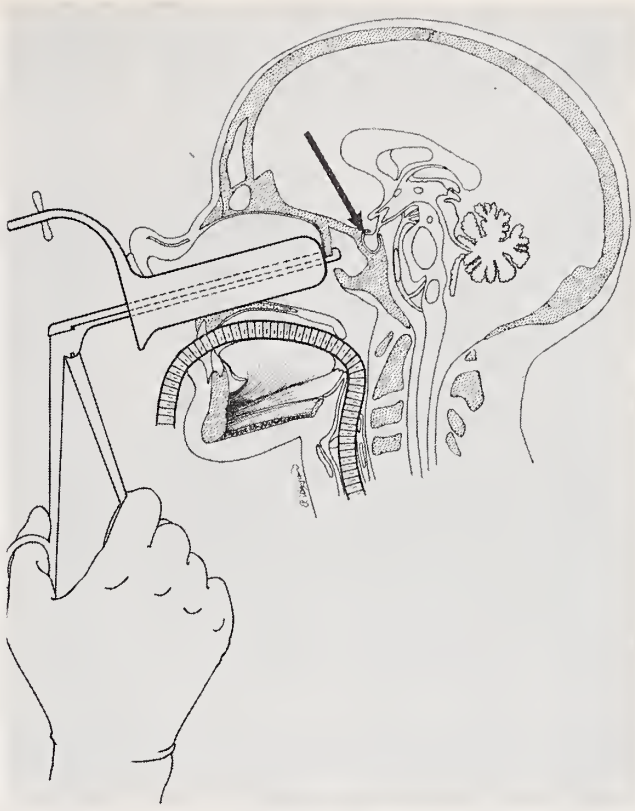


FIGURE 1

Diagram illustrating the operative approach of transsphenoidal hypophysectomy. After making an incision in the upper gingival margin, a submucosal plane is developed along the floor and along the nasal septum. The anterior wall of the sphenoid and the floor of the sella turcica are removed allowing the surgeon to perform a complete removal of the pituitary gland.

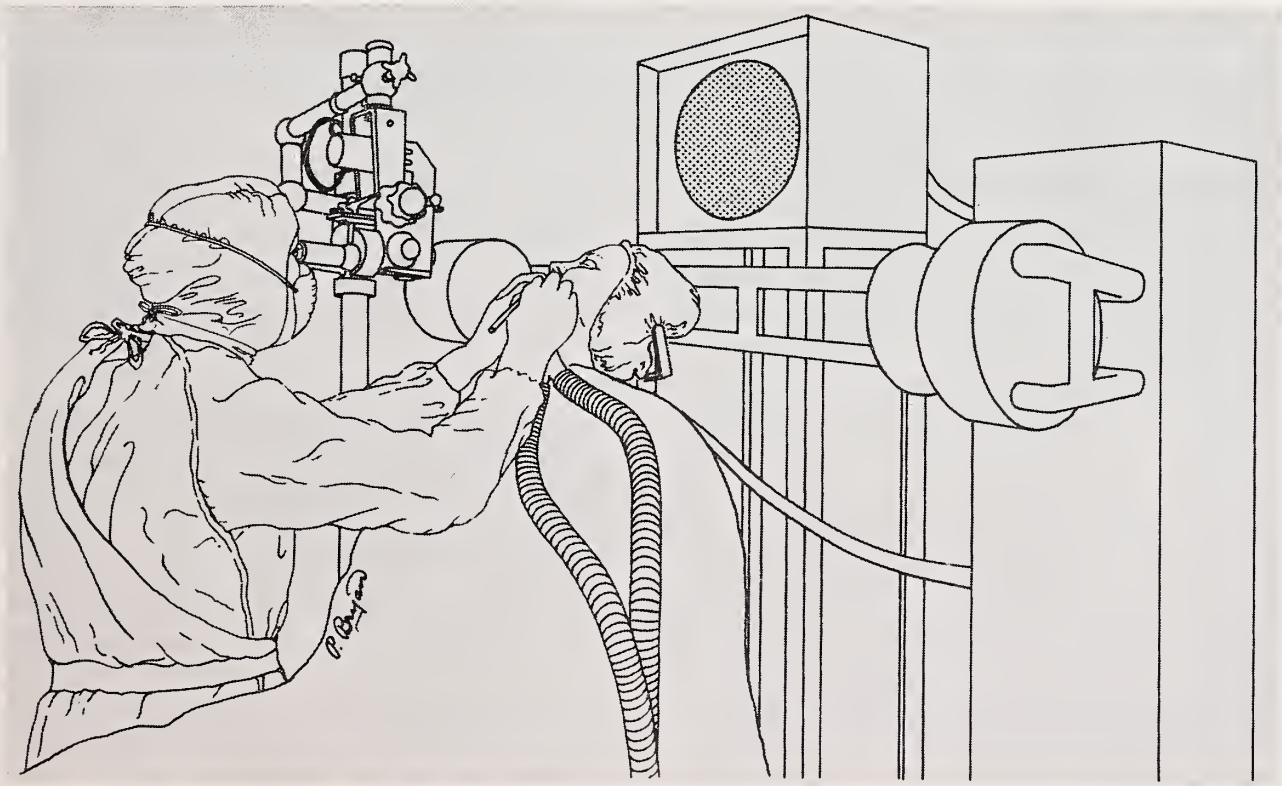
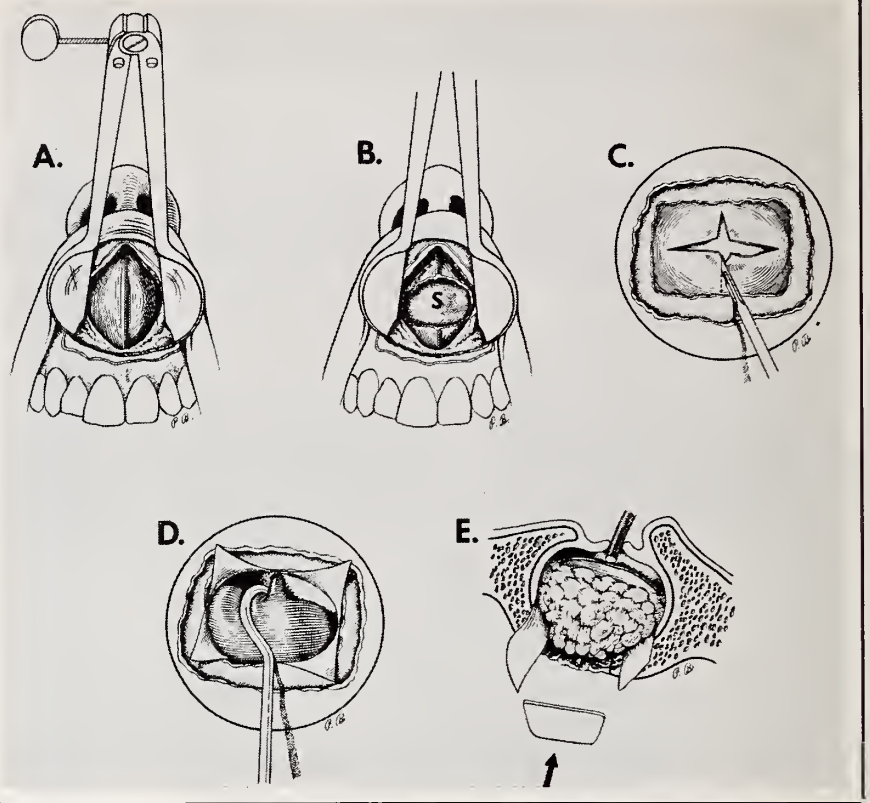


FIGURE 2

Diagram illustrating the relative positions of the surgeon, patient, image intensifier, and operating microscope during transsphenoidal hypophysectomy. The image intensifier controls the anteroposterior approach and also enables the surgeon to locate the exact position of the floor of the sella turcica. The operating microscope provides ideal illumination and magnification and is essential to the performance of total hypophysectomy.

FIGURE 3

Diagram illustrating the important steps of transsphenoidal hypophysectomy. (A) The nasal mucosa is retracted laterally exposing the vomer (anterior wall of the sphenoid sinus). (B) The sella floor is removed with a small Kerrison rongeur. (C) The dura mater over the pituitary is opened in a cruciate manner. (D) Using special instruments a dissection plane is developed between the gland and the surrounding dura mater. Traction is then applied to the gland in a posterior direction exposing the pituitary staik which is sectioned as close to the gland as possible in order to minimize the occurrence of postoperative diabetes inspidus. After cutting the stalk, the intact pituitary gland is easily removed. (E) A fascia-fat graft is placed in the now empty sella and the floor reconstructed using a small piece of nasal septum cartilage.



is discharged from the hospital, or is incomplete (some vasopressin reserve intact) enabling the patient to compensate simply by drinking fluids as dictated by his thirst. The status in this regard can be determined by the eight hour water deprivation test on the 10th postoperative day. At this time all of the tests for pituitary trophic hormone reserve should be repeated with exception of the serum cortisol and urinary steroids which would be vitiated by mandatory corticosteroid replacement therapy.

Convalescent and Postconvalescent Management

By the time of discharge from the hospital, the patient will be on a maintenance dose of hydrocortisone, 20 mg in the morning, 10 mg in the late afternoon, and possibly vasopressin. The patient and family must be instructed to increase the steroids by two to three times the usual dose in the event of severe physical or traumatic stress (fever, severe respiratory infection, accident, etc.) and to notify the physician of the problem. Thyroid replacement therapy is started only when it is ascertained that the patient has become hypothyroid clinically and chemically. Thereafter, corticosteroids and thyroid replacement therapy will be maintained indefinitely. Long-term management of these patients requires a carefully coordinated approach by the primary physician, neurosurgeon and internist (or endocrinologist).

Criteria Indicating Remissions

In patients with advanced breast and prostatic cancer, an objective remission can be measured by a decrease in the size of a lesion either by palpation or with X-rays following hypophysectomy without evidence of advance of other lesions or development of new lesions; disappearance of a neurologic deficit; and/or increase in function of an obstructed organ (e.g., ureter or bowel). In addition, in advanced cancer of the prostate, an objective remission is indicated by a decrease in serum acid phosphatase activity to normal. Most authorities believe that the objective remission should last at least three months to be considered a positive response.

Subjective remission can be assessed by relief of pain; correction or improvement of anemia; gain in weight; and improvement in appetite. As would be expected, subjective remissions occur more often than objective ones. It is noteworthy that relief of pain occurs in the majority of patients with advanced breast and prostatic cancer even though an objective remission cannot be proved.

Results of Hypophysectomy

While a comprehensive review of the results of hypophysectomy for breast cancer is beyond the scope of this publication, a critical review of several of the larger reported series[3, 10, 11, 19, 23] indicates that remissions occur in approximately half of the women who undergo hypophysectomy and that the period of survival in those who respond to hypophysectomy is sigifinicantly increased. Pearson and Ray[19] have the largest series to date. These workers obtained remission in 42 per cent of 343 patients

undergoing hypophysectomy. The average survival in those patients who responded favorably to hypophysectomy was 25.8 months whereas in those who failed to achieve a remission, average survival was only 5.6 months.

In the opinion of the authors, extensive chemotherapy should not be used prior to hypophysectomy in those patients with metastatic disease who are considered candidates for the operative procedure. Conway and Collins[3] found that extensive previous chemotherapy was associated with a less favorable remission rate regardless of prior history of hormone dependence of the tumor. On the other hand, following hypophysectomy, chemotherapy may be more effective as Hall and Wilson have suggested that the effects of major endocrine ablations and chemotherapy may be additive or even synergistic.[7]

The remission rate in patients with disseminated prostatic cancer following hypophysectomy is significantly high, ranging from 60 to 85 per cent among the reported series.[5, 13, 22, 24] In view of this finding, it is surprising that the number of cases of prostatic cancer undergoing hypophysectomy are far outnumbered by patients with advanced breast cancer undergoing the same procedure. Maddy et al.[13] obtained a remission rate in 60 per cent of 20 patients undergoing cryohypophysectomy. The mean duration of the remission was 7 months and the mean survival of the responders was 11.5 months as compared with 3.8 months for nonresponders. These investigators evaluated the residual pituitary tissue following cryohypophysectomy in 18 autopsied cases.[18] It is significant that in 7 of the 18 cases more than 10 per cent of the anterior lobe remained viable. However, Norrell et al.[18] believe that a remission in the majority of patients with advanced cancer will still occur despite failure to destroy the entire gland. Edelstyn et al.[4] challenge this viewpoint and as support for their belief, cite Ganong and Hume's[6] finding that as little as 5 per cent of the anterior pituitary can still stimulate the adrenal cortex. The present authors agree with Edelstyn et al.[4] regarding completeness of pituitary ablation. Thus, the open transsphenoidal hypophysectomy which accomplishes a complete removal of the pituitary would appear to be the preferred method for performing hypophysectomy.

Relief of Pain

Following hypophysectomy, the majority of patients with metastatic breast and prostatic cancer obtain gratifying relief of pain, particularly from the pain of bony involvement. The relief of pain occurs within 24 to 36 hours following total pituitary ablation by transsphenoidal hypophysectomy. Significantly, pain relief occurs even in patients who fail to achieve an objective remission following hypophysectomy.

There is no evidence that hypophysectomy aggravates or hastens the course of breast or prostate cancer if a remission does not occur. Also, this operative procedure does not lead to or predispose to alterations in emotional states or mental functions.[21]

Summary and Conclusions

Hypophysectomy is a useful, gratifying palliative operative procedure in patients with disseminated breast and prostatic cancer. Remissions occur in approximately 50 per cent of patients with breast cancer and in from 60 to 85 per cent of patients with prostatic cancer. In women with breast cancer who have shown a positive response to previous oophorectomy, the remission rate following hypophysectomy may be as high as 90 per cent. In a significant number of patients with breast and prostatic cancer a remission follows hypophysectomy despite the fact that a previous castration procedure and/or endocrine manipulation did not effect regression of the tumor. The relief of pain, particularly osseous pain, is one of the principal benefits of hypophysectomy and occurs in the majority of patients with breast and prostatic cancer irrespective of whether or not there is other evidence of remission of the lesion.

The procedure of choice for performing hypophysectomy is the open transsphenoidal microsurgical approach. This operative technique is considerably safer and less troublesome to the patient than craniotomy and in addition, a complete removal of the pituitary is assured in the majority, if not all, of the cases. Since this procedure is now available, the authors believe that hypophysectomy should be given early and serious consideration in patients with disseminated breast and prostatic cancer. ■

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Duodenal Obstruction in the Newborn

LEWIS DAVIS, M.D., and PETER PHILLIPS, M.D., Atlanta*

DR. LEWIS DAVIS: This is a five-day-old female with recurrent vomiting and abdominal distention since birth. The infant was born following a normal term pregnancy. After an immediate normal neonatal period, the infant was returned to the hospital because of vomiting and abdominal distention. This is the initial examination of the abdomen in this patient. Dr. Phillips, would you comment on it? (Figure 1)

Dr. Peter Phillips: The AP recumbent film of the abdomen reveals a large gas-distended viscus in the upper and mid abdomen representing distended stomach. There is a second smaller gas structure just to the right of this representing the proximal duodenum. The upright film demonstrates air-fluid levels in both of these structures. There is no other gas throughout the intestinal tract with the exception of a very small amount of gas in the region of the distal left colon. Perhaps this gas in the colon is the result of rectal examination.

Dr. Davis: The infant had a rectal exam at the time of admission to the hospital, just before these films were made.



FIGURE 1

Recumbent film of the abdomen demonstrating gaseous distention of the stomach. The arrows indicate gaseous distention of the duodenum. A small amount of gas is present in the distal colon which was introduced by rectal exam.

Three Entities

Dr. Phillips: This is the typical appearance of congenital duodenal obstruction with the site being in the descending duodenum. The differential diagnosis of a lesion such as this includes three entities:

1. Atresia or stenosis of the duodenum.
2. Annular pancreas.
3. Malrotation of the colon with obstruction of the duodenum by congenital bands or associated mid-gut volvulus with the malrotation. These are the basic things that one would have to consider. Another possibility could be duplication cyst of the duodenum with obstruction secondary to the large size of the duplicated segment of the duodenum.

Dr. H. S. Weens: One other condition that should be considered is electrolyte disturbances in the newborn with secondary gastric and/or duodenal ileus such as may be seen with adrenal insufficiency. This is a rare occurrence but should be considered in the differential diagnosis when an infant presents with these radiological findings.

Dr. Phillips: To differentiate between duodenal atresia or annular pancreas and the duodenal obstructions associated with incomplete rotation of the colon, a barium enema should be done. Was a barium enema examination performed?

Dr. Davis: A barium enema was done a few hours following the radiographic examination. These are representative films from the barium enema examination (Figure 2).

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

Dr. Phillips: The right colon is in abnormal position. The cecum is seen high in the right upper quadrant and the appendix is outlined just inferior to the transverse cecum. This finding indicated incomplete rotation of the colon and the most likely possibilities to be considered are congenital bands—called Ladd's bands—compressing the duodenum with obstruction and midgut volvulus.

Dr. J. L. Clements: Is there any configuration to the colon which may help you differentiate between the possibilities of congenital bands or midgut volvulus?

Dr. Phillips: I know of no characteristic configuration of the incompletely rotated colon which would help differentiate between these two entities.

Dr. Davis: At surgery, the obstructing lesion was a mid gut volvulus which accounted for the obstruction of the duodenum. The intestine involved by the volvulus was viable with no evidence of strangulation. The volvulus was reduced and the infant has made an uneventful recovery up to the present time.

Comments

Rotation of the midgut begins approximately in the eighth week of fetal life. Rotation of the gut occurs in three stages. The first stage is a 180° counterclockwise rotation around the superior mesenteric artery while the midgut is out of the coelomic cavity. The second stage consists of return of the gut to the abdomen and a further counterclockwise rotation. The jejunum enters the coelomic cavity first. The small intestine collects on the left and the cecum and ascending colon, the last to enter the abdomen, lies on the right. The third stage is completed near the time of birth or shortly afterwards. At this time, the completion of descent of the cecum into the right lower quadrant and fixation of the cecum, ascending colon and the duodenum occurs.

Arrest most frequently occurs in the third stage resulting in a narrow mesenteric pedicle rather than the normally broad pedicle, and freely movable malpositioned cecum. With this, volvulus is most likely to occur. In addition, peritoneal bands (Ladds' bands) extending from upper peritoneum to the cecum passing over the duodenum may also cause obstruction.[2]

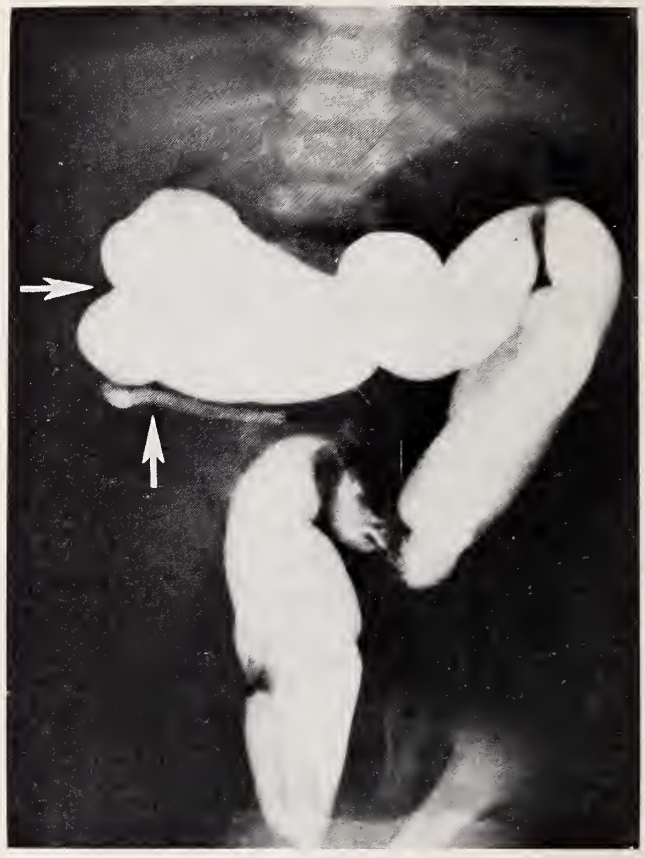


FIGURE 2

Preevacuation barium enema film. The arrows indicate the cecum and appendix in abnormal position, crowded high in the right upper quadrant of the abdomen.

If duodenal obstruction is suggested, one should do a barium enema to exclude the malrotation and therefore obstruction secondary to volvulus and/or Ladd's bands. Also 10 to 15 per cent of patients with malrotation and volvulus may have intrinsic obstruction as a duodenal web. By passing a catheter from the stomach into the jejunum, the intrinsic defect can be identified and both corrected at the initial procedure.[3]

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Trimming MAG's Middle Age Spread

DAVID A. WELLS, M.D., *Dalton**

As organizations mature, they often take on a character and form far different from that envisioned by those who created the first structure for the organization. Such is true of nations and such is true of the Medical Association of Georgia.

The governing councils of MAG, beginning to show signs of middle age spread, have been under critical review by the Committee on Organization and Functions for the past two years. Some far-reaching conclusions have been arrived at as a result of this review and these conclusions will be submitted to the House of Delegates next month.

Ideas Gleaned at Unicoi

Last October, President J. Rhodes Haverty convened a meeting at Unicoi styled as a long-range planning conference. If the participants in the conference could be characterized, one would have to say that a majority lacked any identity with the hierarchy. Some of them had only a vague concept of the present governing structure of MAG and, therefore, could have no interest in preserving the status quo or any portion of it. It is highly significant to note that the conferees at Unicoi reached many of the same conclusions, at least in principle, as have been reached by the Organization and Functions Committee as a result of their painstaking study.

The essence of their respective conclusions is that the MAG Council has grown too large to be an effective, governing body; that it has entirely too many non-voting members; and that it should be streamlined, reduced in size and mandated to meet more frequently in an atmosphere conducive to orderly and scholarly deliberation.

As of the date this paper is written, the Committee on Organization and Functions has not yet finalized its report to the House of Delegates. When that report is written, however, it will roughly address the following points:

The committee will recommend that the name of the Council be changed to Board of Directors and that it be composed of 22 to 25 members. The officers of the Association would be a president, president-elect, secretary, treasurer and speaker of the House of Delegates. The remainder of the Board members would represent districts, trade areas, large county medical societies or a combination of these.

The new Board would have several characteristics which distinguish it from the present Council. These include the absence of "alternates," vice-presidents, past presidents and other non-voting members, and would be required to meet two full days every second month (for a total of 12 days a year) as opposed to the four days a year that present Council meets.

Members of the Board would be elected either by mail ballots cast by all physician members in a given district or by those members of the House of Delegates from that district. The five previously named officers would continue to be elected by the House as is currently done.

The five officers would constitute the Executive Committee, which would meet only on call, rather than monthly as is presently the case.

The President would preside over the Board of Directors and the Executive Committee. It seems perfectly logical that the individual elected by the House as the leader of the Association should preside over the body that has leadership responsibility. To deny him that prerogative seems inconsistent with any orderly or constructive rationale.

Summary Comparison

The following is a summary comparison between the present Council and the proposed Board of Directors:

Present Council	Proposed Board
28 voting members 45 ex-officio, non-voting members	22 voting members No ex-officio No alternates
73 TOTAL MEMBERS	22 TOTAL MEMBERS
Meets 4 times a year for a total of 4 days	Meets 6 times a year for a total of 12 days
Presided over by Chairman elected by Council	Presided over by President

* Chairman of the Ad Hoc Committee on Organization and Functions and President-Elect of the Medical Association of Georgia.

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Government's Expanding Involvement

ELSEWHERE IN THIS ISSUE PL 93-641 is summarized by J. Gordon Barrow, M.D. and Robert A. Youngerman, J.D.

With a reading of just this brief review of the law, it is apparent that the federal government has taken a giant step in its expanding involvement in health care delivery. The new agencies, HSAs, established by the law will be responsible for: 1) developing a health plan for an area including *its* perception of health priorities; 2) developing and funding projects and programs that fit into the health plan for the area; 3) coordinating its activities with PSROs including the securing of data for planning; 4) reviewing and approving or disapproving the use of a wide variety of other federal funds coming into the area; 5) making recommendations to the state agency respecting the need for new institutional health services in the area; 6) making recommendations to the state agency at least every five years as to the appropriateness of all institutional health services in the area; and 7) making recommendations to the state agency respecting projects for the modernization, construction, and conversion of medical facilities in the area.

Additionally, this health planning legislation allows:

1. The Secretary of HEW to have wide discretionary authority over the HSA's performance and structure.

2. The Secretary of HEW to promulgate regulations and guidelines that in many instances could add additional responsibilities to the agencies.

3. Once an organizational structure of this kind is in place, and exists on federal funds, it is subject to the direct importunings of the Federal government to become involved in more areas of health care.

The critical factor for organized medicine to be cognizant of in regards to this law is the absolutely essential need for physician involvement in the structuring development and operation of the HSAs. Only through active participation by physicians from the earliest stages of this law's implementation, can we insure that the best interest of patient care will be served in the decisions made by the HSA's Board of Directors.

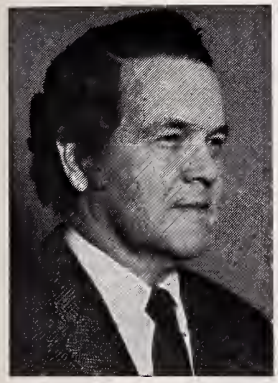
There is a very definite role for physicians to play in the HSAs, and I would encourage every MAG member to familiarize himself with the health planning activities that are occurring in his area and take an active part in them.

We shall endeavor to keep physicians informed about the progress of implementing this new law. It bears close observation by all of us and more importantly requires our involvement.

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president's letter

L'envoi



THIS IS THE LAST of my "President's Pages." I have been greatly honored by those I most honor and respect, and this year has meant much to me. I am thankful to all who have made it a wonderful experience. It has been time-consuming, and occasionally onerous, perplexing and exasperating, but overall it has been enjoyable and highly satisfying.

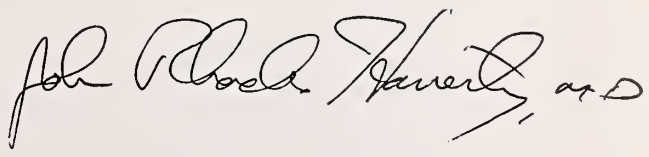
The conclusion of an appointment where one has been selected as a leader by his peers is perhaps one of the few opportunities someone not of the clergy can be permitted and excused for preaching. I shall take that opportunity now. If I irritate by doing so, forgive me by realizing what I say is with deep love for my profession.

Perhaps individually we are some of the few noble creatures left in this world: those who really believe in the dignity of man and who truly serve others. But collectively we don't come across that way very often. As individuals and as a group, we need to tell our stories of unselfishness, of usefulness, of dedication and of caring. But also we do have feet of clay, like all other mortals, and we should remember it, for the public sees evidence of that humanness and brings it to our attention forcefully when we do not live up to the ideals created for us.

For example, it's hard to be sympathetic to or admiring of a physician who complains of being put upon financially. It's hard for the public to understand how we can preach good health care for all at one moment, and fight about the terms of the delivery of such health care at another. It's difficult for many to excuse the arrogance of some physicians in dealing with their patients or with those others who also are serving as devotedly and selflessly.

Let us accept that we have weaknesses, then work toward eliminating them. Let us remember that the prime object of medicine is to serve society. We are society's authority on health and its disorders. We are also the logical advocates of the consumers of health services and should be speaking constantly in their behalf. By serving society in these ways, we'll be serving ourselves as well. We are not just a "physician's protective association," but we will protect and defend ourselves magnificently by speaking out for our patients, and the betterment of their health.

Mme. Maintenon is supposed to have said once to King Louis XIV, "Remember, sire, it is not enough to be wise; in the end you have to please." We must please, too. We must satisfy the public by using our peculiar talents, because if we do not, we will have no further reason for existing. But if we do, again we will find ourselves justly exalted as children of God and brothers of man.



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

heart page
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LBBB (Left Bundle Branch Block): Diagnostic of Nothing?

I. W. JOINES, II, M.D., *Atlanta**

THE ELECTROCARDIOGRAPHIC PATTERN of left bundle branch block (LBBB) reflects the altered or delayed conduction within the ventricular system of an electrical impulse arising in a supraventricular pacemaker (sinus, atrial or nodal). Well into the 1960's, most knowledgeable physicians felt secure in diagnosing serious or significant heart disease in patients based solely on the electrocardiographic finding of LBBB even in the absence of other signs or symptoms to support the diagnosis. Most patients with LBBB were presumed to have coronary artery disease (otherwise silent), hypertensive heart disease, cardiomyopathy and/or valvular heart disease resulting in their being assigned poor prognoses and managed accordingly. With the advent of selective coronary arteriography and more sophisticated means of studying the pathophysiology of the myocardial conduction system, the past decade has witnessed the accumulation of a wealth of new information to indicate that the isolated finding of LBBB on the electrocardiogram of patients otherwise lacking symptoms or signs of heart disease is often a benign condition.

Beach and associates reported a study of 10 patients without signs or symptoms of underlying heart disease who had normal cardiac catheterization including coronary arteriograms.[1] In a less select group of 24 patients with LBBB studied by comparable methods, Haft found seven patients who had significant coronary artery disease (always severe); five had cardiomyopathy and seven had valvular disease (three had both aortic and mitral disease and five had rheumatic fever by history). Only those with CAD (coronary artery disease) or cardiomyopathy had abnormal left ventricular contraction patterns on cineangiocardiography; 13 patients were male and 11 female; mean age was 48.1 years for males and 48.3 years for females.[2]

Gould has gathered prognostic data in patients with coronary artery disease and LBBB. Of 27 patients with LBBB following acute myocardial infarction, five died. LBBB was present in 26 patients on admission and later appeared in one. Fourteen of 16 patients who did not have a temporary transvenous pacemaker inserted as a prophylactic measure survived the AMI. Of the 22 survivors, 16 were alive an average of 12.7 months after the AMI. Thus, it would appear that LBBB in AMI has little, if any, effect on prognosis and is not an indication for prophylactic insertion of a transvenous pacemaker (or of a permanent pacemaker).[3] LBBB has been found to be infrequent as compared to RBBB in AMI and the latter has more association with asystole and complete heart block and need for a pacemaker.

Causes of LBBB

Experimentally, LBBB can be produced by:

1. Cauterizing of one or both of the ventricles
2. Cooling or icing of one or both of the ventricles
3. Electrolyte disturbance such as hypokalemia or hyperkalemia

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4. Internal or external manual or mechanical pressure upon the free wall of the ventricular system.

Some suggest the term "conduction delay" rather than "bundle branch block" (anatomical connotation) since the delay can be in the initial or terminal portions or the whole QRS complex; therefore, the "block" or delay can be in the conduction system or free ventricular wall.

Microanatomical studies of patients with LBBB dying of heart disease reveal a high number with degenerative and fibrotic lesions in a small central area just at the origin of the left bundle branch.[1]

Conflicting reports exist on the effects of coronary anatomy on occurrence rates of LBBB. Short LMCAs (left main coronary arteries) and dominant LCAs (left coronary arteries) (major contribution to the posterior descending artery) have been shown to have a frequent association with LBBB in some studies while others show no differences between LBBB patients and control group patients in either length of the LMCA or in the so-called "dominance" of the coronary circulation (that is, which artery contributes to or supplies the posterior descending branch). Coronary anatomy, therefore, does not appear related to the presence of LBBB.

Clinical Considerations

Office evaluation of patients with LBBB has been limited in the past since electrocardiographic clues to the underlying significance have been felt to be unreliable. The consensus is that the mean QRS vector in LBBB has no prognostic or diagnostic value whether normal or abnormal. However, the stress treadmill electrocardiogram may be of considerable value since evidence suggests that less ST segment depression occurs in benign LBBB as compared to patients with ischemic heart disease and LBBB. Those patients who perform well on the treadmill and have no clinical angina pectoris or ST segment depression from the baseline resting electrocardiogram should be studied with cardiac catheterization, selective coronary arteriography, cineangiocardiography and His bundle recordings if ischemic heart disease has been previously diagnosed on the basis of confusing or atypical symptoms and the presence of LBBB on resting electrocardiograms.

Summary

Patients with LBBB frequently have no demonstrable heart disease and may have a good prognosis. The diagnosis of coronary atherosclerosis or ischemic heart disease should not be made solely on the presence of the LBBB pattern on the electrocardiogram. Long term follow-up is needed to gain insight into the likelihood of development of serious lesions such as complete heart block. ■

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National Health Planning and Resources Development Act of 1974

(OR, YOU AIN'T SEEN NOTHING YET)

J. WINSTON HUFF, *Atlanta**

On January 4, 1975, President Ford gave his approval to Public Law 93-641, the official caption of which is set forth above. This comprehensive Act adds two new titles to the Public Health Service Act: Title XV relates to "National Health *Planning* and Development"; and Title XVI covers "Health *Resources* Development." This law is 52 pages long (in small print) and complex. Layer upon layer of agency, sub-agency, council, plans and various bodies are created. It is not possible to cover the entire Act in any detail. This article can only attempt to give you an indication of its principal provisions.

National Health Planning and Development

Priorities: Congress finds and declares our national health priorities to be: primary care in underserved populations; development of multi-institutional systems for coordination and consolidation of services (obstetrics, pediatrics, emergency, coronary and intensive care and radiation therapy); development of medical group practices and HMOs; training and increased utilization of physician assistants and nurse clinicians; multi-institutional sharing of support services; improvement of quality, including the needs identified by PSRO; institutional care on a "geographically integrated basis"; disease prevention; uniform cost accounting, better systems for reimbursement, utilization reporting and management procedures; and public health education.

National Guidelines: The Secretary of HEW is directed, within 18 months, to issue guidelines governing national health planning policy, including standards for supply, distribution and organization of health resources and national health planning goals along the lines of the policy objectives above set out. These, wherever possible, must be cast in "quantitative terms."

National Council: A "National Council on Health Planning and Development" is set up in HEW to advise the Secretary on national guidelines, the implementation of the new law and the evaluation of new technology for the organization, delivery and "equitable distribution" of health care services. This Council is composed of 15 members appointed by the Secretary with certain Federal health officials as ex officio members.

Health Service Areas: The Act establishes within each state "Health Service Areas," generally having a population of not less than 500,000 nor more than three million. These areas in the main are designated by the governor of each

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* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

state provided HEW criteria are met. (It is not entirely clear to me, but it seems that an "area" can lie in more than one state.)

Health Systems Agencies: In each Health Service Area there will be established a "Health Systems Agency." This can be a private non-profit corporation, a public planning body or a unit of local government. Each "agency" would have to provide certain expertise, would have to employ a minimum number of employees and a majority of its governing body is to be composed of consumers.

The functions of each "agency" are described as: improving health in its area; increasing the accessibility, quality, etc. of health services; "restraining" costs; and preventing unnecessary duplication of health resources. Also, the agency will provide health planning and resource development and collect and analyze data on health status, delivery systems, existing resources, and patterns of utilization. The agency will devise and review annually a Health Service Plan ("HSP") and an Annual Implementation Plan ("AIP"). The Agency would coordinate its activities with the local PSRO. It will be the body which approves all grants within its area under the Area Health Services Development Fund, Public Health Services Act, Community Health Service Act, and Alcohol Abuse Prevention, etc. Act. It would review and recommend to the state agency (see below) the need for new institutional services, priorities for modernization, improvement and the like. Planning grants will be available to each agency.

State Health Planning and Development Agencies: The Secretary of HEW is directed to enter into agreements designating a "state agency" for each state. The function of a state agency is to administer the "State Administrative Program" which is the program devised to perform and carry out the state's health planning and development functions. Among other things, it would include all state health planning activities, serve as the designated agency under certain portions of the Social Security Act, administer a "certificate of need" program, prepare a statewide health plan (made up of the HSPs described above) and review all institutional health services.

Statewide Health Coordinating Council: Each state agency must be advised by a "State Health Coordinating Council" for that state. This Council must have at least 16 members composed of consumers, providers, representatives of the state health systems agencies, etc. The Council will review annually and coordinate the HSPs and the AIPs, review and revise a state health plan, conduct public hearings on this plan, review the Health Systems Agencies' budgets, review grant applications, etc.

Rate Regulation and Grants: Grants will be available (on a sort of trial basis) for "the purpose of demonstrating the effectiveness of state agencies regulating rates for the provision of health care. . . ." Also, grants are available for planning and development. The Secretary is authorized to give technical assistance to agencies (both health systems agencies and state agencies).

Health Resources Development

The purpose of this portion of the Act is to provide monetary allotments, loans, guarantees and other subsidies for "projects" for the modernization of medical facilities, construction of new outpatient facilities, construction of new inpatient facilities and conversion of existing facilities to provide new health services. Also included is assistance for construction and modernization of projects designed to prevent or eliminate safety hazards in medical facilities.

Before any such project can be approved for federal assistance, the state must submit and have approved by HEW a State Agency Medical Facilities Plan, which apparently would cover needs of the entire state. Then, assuming a particular project is included in the plan, an application for funding is made for that project. The law sets forth what must be included in the application, including a finding by the state agency that there is "a continuing need" for the service. The Secretary of

HEW is directed to issue regulations prescribing the manner in which the state agency, in its plan, shall determine priority of projects within the state.

Each fiscal year, HEW will make "allotments" to each state based on population and financial and medical needs. The state agency will certify work progress to the Secretary on each approved project and the Secretary will forward the money to the state for payment for the work. Payments can be withheld if the law is not complied with. Loans and guarantees are also available. This portion of the Act replaces the old Hill-Burton program. Finally, at just about the end of this Act, blessed assurance that there will be no federal interference is given as follows:

> "Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance or operation of any facility with respect to which any funds have been or may be expended under this title."

Are you reassured? ■

HIGHLIGHTS OF EXECUTIVE COMMITTEE

February 16, 1975

Membership Opinion Poll on PSRO: It was reported that there have been 1,831 responses as of February 14.

Chiropractic "Physicians": A report was received that there is neither a provision for nor a prohibition against chiropractors using the term chiropractic "physician." Legal counsel did say that the term "physician" appears numerous times in state law and only in terms of a medical doctor. Therefore he felt that should it become necessary, a good case could be made to prevent a chiropractor from calling himself a physician.

MAG-GHA Co-sponsor MATS: Approved the co-sponsorship with the Georgia Hospital Association of a Medical Audit Team Seminar (MATS) tentatively scheduled for May 22-23.

Hospital Utilization Review Plan: Appointed an Ad Hoc Committee to Study the Blue Cross Criteria. The committee was charged to determine the method of obtaining and developing the criteria for length of stay and continuous stay and to distribute this criteria to hospitals to adopt or alter. Appointed to the committee were: Louis H. Felder, Atlanta; D. R. Mahan, Jr., Dalton; H. L. Moreno, Atlanta; James E. Averett, Atlanta; James B. Dunaway, Griffin; and Lee H. Battle, Rome, chairman.

MAG Scientific Assembly for 1975: Received a report that the first MAG Scientific Assembly has been scheduled for November 21-22 in Atlanta. The MAGNET meeting will be held immediately following the scientific meeting. There will be $500 or $1,000 available to specialty societies who wish to participate in the Scientific Assembly.

Professional Liability Insurance: Received a report that St. Paul Companies has announced a change in the types of insurance available to physicians in Georgia. The new policies will be written on a "claims made" basis rather than the present "occurrence" basis.

MAG Committee Structure: Approved several changes that will help make the committee structure operate more efficiently.

Appointments: Samuel W. Pangburn, administrator of West Paces Ferry Hospital as ex-officio member of the Ad Hoc Committee to Study Physician's Assistants. Nominated for two vacancies on the Workmen's Compensation Board—Beverly B. Sanders, Macon; Paul L. Bradley, Dalton; J. D. Christian, Jr., Augusta; C. C. Moreland, Monroe; George F. Green, Sparta; and Walter S. Dunbar, Atlanta. Appointments made by Governor Carter to the State Board of Medical Examiners which have been ruled legal by the Attorney General—George T. Mims, Marietta; M. Virginia Tuggle, Decatur; J. Duncan Farris, Waycross; and Bernard J. Bridges, Atlanta.

I've told this before . . .

(Ed. note: Dwindling returns can cause concern as author J. G. McDaniel, M.D. shows in this human interest story of the plight of one lender and how he handled a "stingy" borrower. Others wishing to contribute to this page should contact the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

A Little Fudging

Joe Westbrook, my next door neighbor, tells an interesting story that happened in his boyhood at Moultrie, Georgia. Joe, as some of you will remember, was one of Georgia Tech's football guards that played on the famous Rose Bowl team in 1928. This was the game that will always be remembered as the one where Roy Reigal of the University of California recovered a fumble and ran the wrong way. He would have scored some points for Tech had not one of his own men tackled him just before he crossed the goal line.

But that is beside the point. In Joe's boyhood his father owned a farm some few miles from Moultrie. Down the road a little ways lived a tenant farmer. Late one spring afternoon the farmer's son came riding up on a mule and told Mr. Westbrook that they had run out of side meat and that his Pa wanted to know if he would let him have a piece of meat until he could get to town the following week. Joe's daddy went into the smoke house and cut off a nice chunk of side meat. In about 10 days, there came the little boy back and returned the meat. Then they gave out again.

This went on all summer: borrowing and returning meat. Mr. Westbrook began to suspect that the piece they were returning was not quite as big as the one he lent. For this reason, he cleaned out a special corner in the meat box and this time when the meat was returned he threw it in that corner. From then on he let them have the same piece of meat that they had brought back some weeks before. The piece of side meat got smaller and smaller and smaller.

Finally the little boy said, "Mr. Westbrook, Pa said could you let him have a bigger piece this time? Pa said you been fudging on him little lately!"

J. G. McDaniel, M.D.
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Atlanta, Georgia 30327

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SOCIETIES

The February meeting of the **Bibb County Medical Society** featured a report on the 1975 AMA Leadership Conference by attendees Hugh Smisson, John Etheridge and Jack Menendez.

Fourth District Congressman Elliott Levitas was the guest speaker for the January 24 meeting of the **DeKalb County Medical Society.** The meeting provided the opportunity for exchanging opinions on legislation critical to the medical profession with Mr. Levitas, a freshman congressman who defeated Ben Blackburn in the November elections.

Robert Grove is the new president of the **Dougherty County Medical Society,** aided by William Mayher as vice president and Gray Rawls serving as secretary.

Georgia Medical Society has installed Thomas R. Freeman as president and Franklyn P. Bousquet, Jr. as president-elect. Other officers are Edgar J. Filson, vice president, J. Robert Logan, secretary, and Dearing A. Nash, treasurer.

The first joint meeting of the Medical Association of Atlanta and the Atlanta Bar Association took place February 4 at the Cherokee Town and Country Club. Guest speaker was Judge Jacob D. Fuchsberg of New York City, who serves as chairman of the Interprofessional Committee of Doctors and Lawyers of New York and founder and editor emeritus of *Trial Magazine*.

PERSONALS

Second District

Rudolph Bell of Thomasville was named Senior Citizen of the Year February 3 by the Chamber of Commerce of Thomas County. Dr. Bell, 71, served as a Thomasville physician 40 years. The Medical College of Georgia graduate had served as president of Archbold Memorial Hospital staff, Thomas County Medical Society, Georgia Urological Association, the Southeastern Section of the American Urological Association and the Medical College of Georgia Foundation.

Fourth District

L. C. Buchanan, Decatur, has been presented the 1974 Julius A. McCurdy Citizenship Award of Decatur Federal Savings and Loan Association as the physician who has contributed the most to the community. In presenting the award, bank president J. Robin Harris said, "Dr. Buchanan epitomizes a lifetime of service to others, to ideals and to his community." Buchanan is currently Speaker of the MAG House of Delegates.

Fifth District

Donald E. Mees, Jr. and **Evan L. Frederickson,** Atlanta, co-authored "Anesthesia and the Porphyrias" which appeared in the January *Southern Medical Journal*. Other Atlantans with papers appearing in that journal include John N. McClure, Jr. and Donald Rooker.

James H. Larose recently returned from chairing the Oncology Session at the First World Congress of Nuclear Medicine held in Tokyo-Kyoto, Japan.

John D. Martin, Jr., professor emeritus of surgery and former chairman of the Department of Surgery at Emory, has received the Distinguished Service Award of the Southeastern Surgical Congress. The award was presented at the SSC's 43rd annual assembly in Atlanta February 17.

Seventh District

Mark M. Lindsey, chief of the Emergency Room Physician's Group of Kennestone Hospital in Marietta, is the new vice speaker of the Council for the American College of Emergency Physicians. Dr. Lindsey also serves as councilor from Georgia and is president-elect of the 60-member Georgia chapter.

Tenth District

Robert G. Ellison, Charbonnier Professor of surgery and chief of thoracic surgery of the Medical College of Georgia, was presented the 5th annual Distinguished Service Award of the Society of Thoracic Surgeons at the annual meeting of the society in Montreal recently. Dr. Ellison was treasurer of the Society six years, president of the international group three years ago, and was instrumental in organizing the 1,400 member society of the United States and Canada.

P. Syamasundar Rao, of the Department of Pediatrics, Medical College of Georgia, has been elected to the International College of Pediatrics and has been awarded the degree of Fellow of the International College of Pediatrics.

DEATHS

C. Walter Coolidge, Jr.

Atlanta physician C. Walter Coolidge, Jr., 51, died December 28 in a boating accident in Hilton Head, S.C. Dr. Coolidge was state chairman of the American College of Gynecology, a member of the Atlanta Obstetrical Society, the Georgia Obstetrical and Gynecology Society and was past president of the Medical College of Georgia Alumni Association.

Dr. Coolidge was a senior staff member of Crawford W. Long, Emory University, Georgia Baptist, Doctors Memorial and Shallowford Community hospitals. He was a member of the Savannah Yacht Club, Hilton Head Yacht Club and the Southeastern Racing Association.

Survivors include his widow, Joan Thomson Coolidge; daughters, Lisa Jan Coolidge, Ann Thomson Coolidge and Alexandra Cumming Coolidge, all of Atlanta; son, Charles Ruthven Coolidge of Atlanta; and mother, Mrs. C. Walter Coolidge of Hilton Head.

Hugh G. Mosley, Sr.

Hugh G. Mosley, Sr., 75, of Atlanta died January 29 following a stroke. The 1925 graduate of Emory University School of Medicine served his internship and residency at Grady Memorial Hospital, after which he practiced in Atlanta from 1927 to 1974.

He was a veteran of World War I and II, serving in the U. S. Army. Dr. Mosley served on the staff of Crawford W. Long Hospital and Hugh Spalding Hospital, and at one time belonged to the Atlanta Obstetrical Society. He was a member of Phi Kappa Alpha fraternity and Theta Kappa Psi medical fraternity.

William W. Puett

A pioneer physician in the Norcross area William W. Puett died January 12 at the age of 91. The general practitioner had served Gwinnett county for more than 40 years before his 1971 retirement.

The Cumming native attended the University of the South in Sewanee, Tenn. and received his medical degree from Atlanta College of Physicians and Surgeons, now Emory. After practicing in South Georgia, Dr. Puett came to Duluth in 1930 and to Norcross two years later.

Dr. Puett was a York Rite Mason, a Shriner and a member of the Norcross United Methodist Church.

Survivors include his son, Col. (Ret) Joseph Puett of Atlanta; foster son, Thomas H. Fallow, Jr.; grandchildren and great-grandchildren.

Bernard Strickman

Bernard Strickman, 44, of Atlanta died February 5. The internist was a diplomat of the American College of Internal Medicine and a member of the Cobb County Medical Society.

He is survived by his widow, the former Miriam Cherrin; son, Andrew Strickman, Brian Strickman, Craig Strickman and Deron Strickman, all of Atlanta; parents, Mr. and Mrs. Leon Strickman of West Palm Beach, Fla.; sister, Mrs. Flora Fox of Philadelphia, Pa. and a step-brother, Erv Alper of Atlanta.

ABFP CERTIFICATION EXAMINATION SCHEDULED FOR NOVEMBER

The American Board of Family Practice will give its next two-day written certification examination November 1-2, 1975 at five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing:

Nicholas J. Pisacana, M.D., Secretary
American Board of Family Practice, Inc.
University of Kentucky Medical Center
Annex #2, Room 229
Lexington, Kentucky 40506

Please note: It is necessary for each physician desiring to take the examination to file a completed application with the Board office by June 15, 1975.

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Advance Registration

Advance registration is required. Please complete the form below and make checks payable to the Woman's Auxiliary of the Medical Association of Georgia. Mail to Mrs. Hagan Baskin, 2283 Sagamore Hills Drive, Decatur, Ga. 30033.

APRIL 17			
2 to 5 p.m.	Registration Fairmont Hotel	$ 2.00	.....
7:30 p.m.	Evening Out Sheraton Biltmore Hotel, Wit's End Players, Dinner and Show (Provide Own Transportation)	12.00 (per person)	.....
APRIL 18			
12:30 p.m.	Luncheon and Tour	10.00	.....
	Luncheon at Anthony's Only	8.50	.....
	Tour of Swan House and Tully Smith House only (Transportation Provided)	1.50	.....
7:30 p.m.	Evening Out Dinner at Rue de Paris, Underground (Provide Own Transportation)	12.00 (per person)	.....
APRIL 19			
8:30 p.m.	Past President's Breakfast Fairmont Hotel	6.75	.....
1 to 3 p.m.	Luncheon and Fashion Show Fairmont Hote	10.50	.....
		TOTAL:	.....

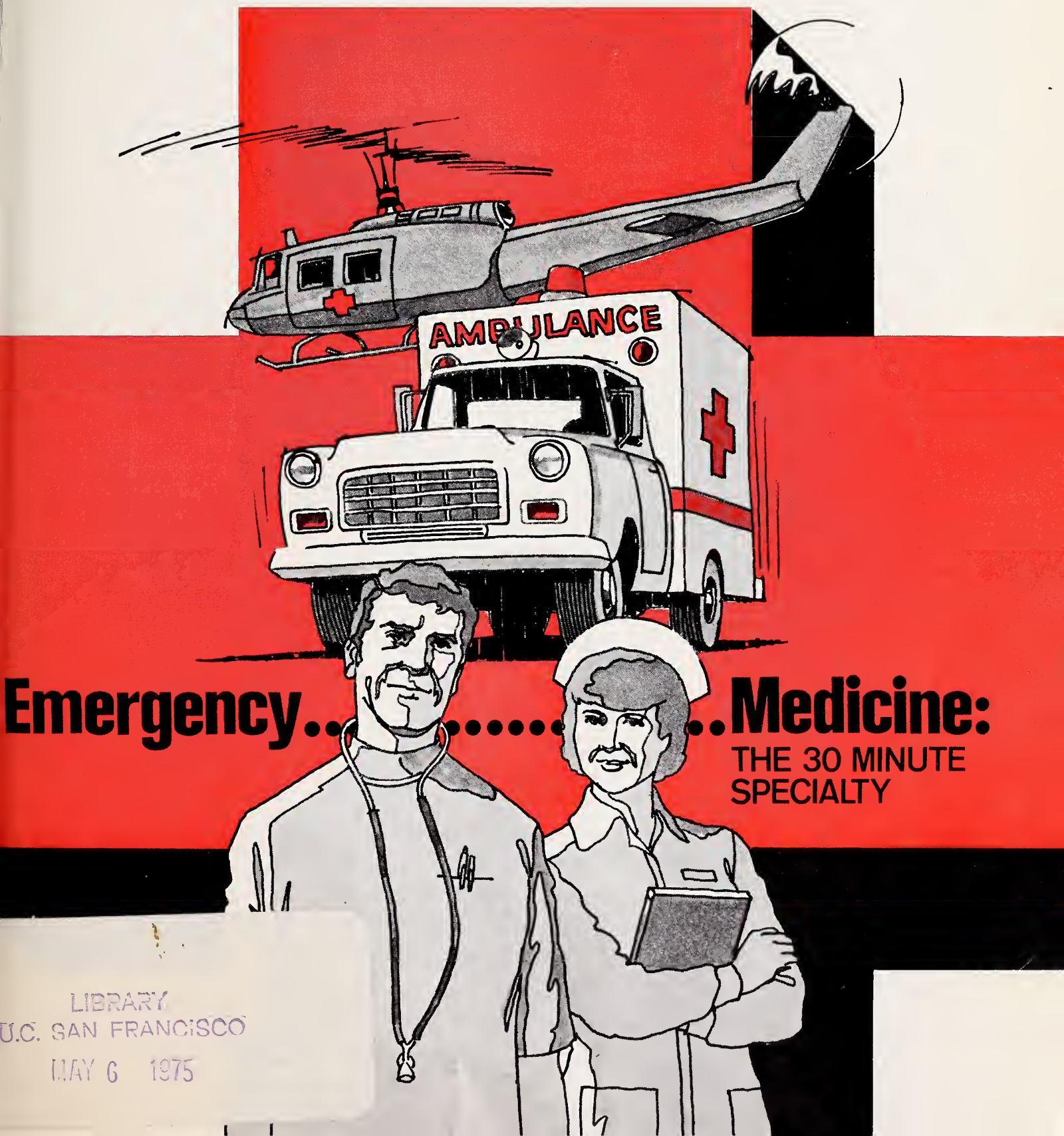
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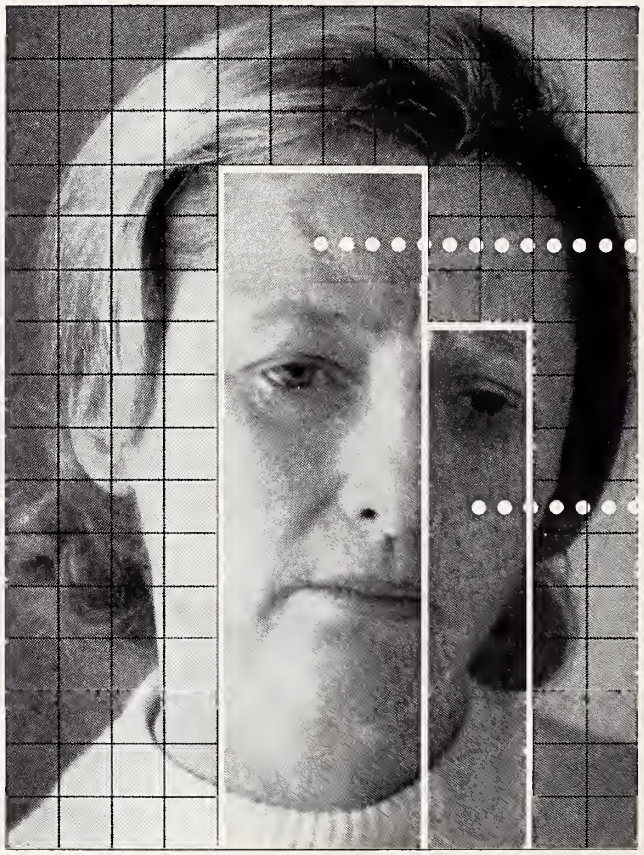
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and mus cle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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of the medical association of georgia

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OFFICE OF PUBLICATION
The Ovid Bell Press, Inc.
1201-05 Bluff Street
Fulton, Missouri 65251

Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1975, Medical Association of Georgia.

Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

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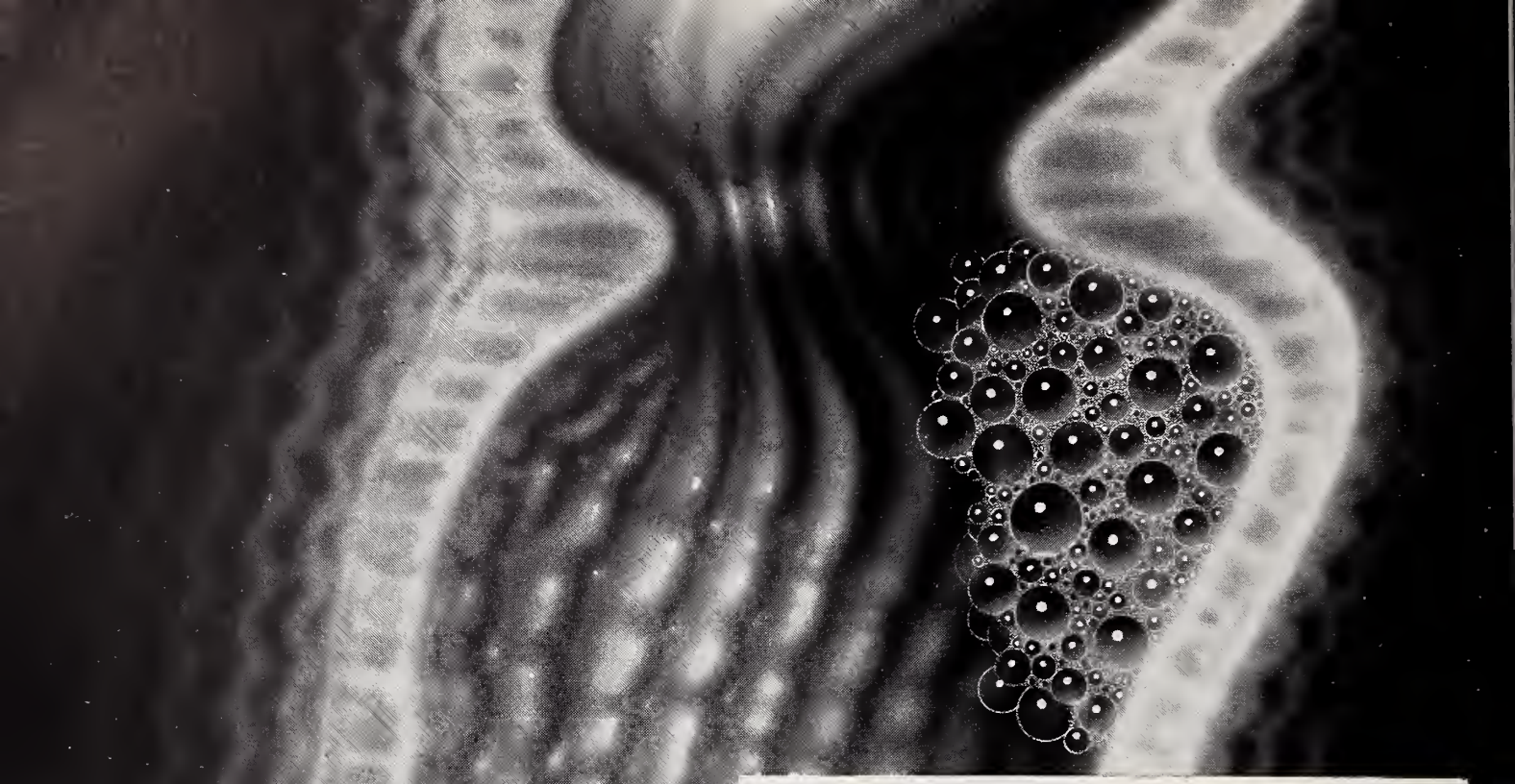
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THE COVER

The first 30 minutes of any illness are what the emergency physician must be able to manage, explains Selwyn T. Hartley, M.D. in his editorial on page 106. This newest specialty and various plans to deal with emergency situations are explored in the April issue.



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Saving Lives with MAST: Military Assistance to Safety and Traffic

Designed to complement local public and private emergency services, MAST can extend available aid as long as basic procedures are followed.

TIME, THE CRUCIAL FACTOR that often means the difference in emergency cases, is becoming less of a problem thanks to a unique program coordinating military and civilian resources in Georgia. MAST, for Military Assistance to Safety and Traffic, which provides helicopter "ambulances" when other modes of transportation are unavailable or unsuitable, has been in effect for nearly a year at four locations in and around the state.

The premature infant who must be transferred immediately to another hospital, the accident victim who cannot be reached by ground transportation, the ailing patient who must be supplied with a donated kidney miles away as quickly as possible—these are the typical cases in which MAST has meant the difference.

When an authorized call comes from a physician, highway patrolman or hospital administrator and reaches the participating MAST headquarters at Ft. Benning and Ft. Stewart, Georgia, Ft. Rucker, Alabama or Ft. Jackson, South Carolina, a helicopter can be on its way in minutes to meet the needs of the emergency within the general 100 mile radius covered by each site.

Those who have set up the programs hope physicians around the state will become familiar with the service and how invaluable it could be in the right situation. To insure its effective and safe use, specific operational procedures have been put into effect. Knowing these procedures can smoothly speed your request and the mission on their way.

Above all, MAST is charged with responding "efficiently and effectively to serious civilian medical emergencies which are beyond the capabilities of available local private or public emergency services." MAST was not created to compete with other established agencies, but was directed to provide supplementary service for serious medical emergencies. These are defined as "situations in which an individual's condition requires that he be evacuated to a selected medical care facility as soon as possible in an attempt to prevent death or the aggravation of illness or injury." Usually the ambulance will be the first to arrive at the scene of an accident and transport the patient to the nearest hospital. The physician would decide if the patient is classified as an emergency transfer.

Background of MAST

The original concept for the MAST program came from the Department of Transportation proposal to the Department of Defense that military helicopters and emergency medical skills be used to assist highway accident victims. In August 1969, the Secretary of Defense proposed further investigation of the concept. A study group was formed with representation from the Departments of Defense; Health, Education, and Welfare; Transportation; Interior; Justice; and the Office of Emergency Preparedness.

It soon became apparent that MAST units could respond to other emergencies, such as hunting accidents, heart attacks and farm accidents. Other valid MAST operations could be the interhospital transfer of patients, premature infants, the pickup and delivery of blood, medicine and human organs for transplant. Wherever even non-critical patients were in remote or otherwise inaccessible areas impractical for other ground transportation, a military helicopter could be invaluable. In addition, medics, trained and many experienced from service in Vietnam, could put their training to good use.

From mid-July to December 31, 1970, the feasi-

bility of the MAST concept was tested at Fort Sam Houston, Texas; Fort Carson, Colorado; Fort Lewis, Washington; Luke Air Force Base in Arizona; and Mountain Home Air Force Base in Idaho. The following October the study group, later known as MAST Interagency Executive Group, recommended expansion of the program. While the Secretary of Defense approved continuing the project at the test sites, he felt actual expansion should await legislation authorizing Department of Defense participation.

In November 1973, Public Law 93-155 authorized the three Departments of Defense, Health, Education, and Welfare and Transportation to provide military transportation services to civilians in emergencies. There were certain restrictions:

1. Assistance could be provided only where military units able to provide it were regularly assigned. These units should not be transferred from one area to another to provide such assistance.

2. Aid was to be provided only to the extent that in doing so it did not interfere with the performance of the military mission.

3. Assistance should not increase funds required for the operation of the Department of Defense.

Active operations have been continued at four of the original five test sites since 1970, while one was discontinued when the supporting military resources were transferred to a different location. There are now 15 programs in operation with three to begin soon. Local MAST operation, coordination and administration is the responsibility of the MAST coordinating committee made up of community members in the geographic area served by a MAST site. Day to day operation is supervised by a civilian coordinator appointed by the committee and a military officer designated by the local military unit.

MAST Begins at Local Bases

Ft. Benning, Georgia began planning for its MAST program in August 1972 when civilians from the 54-county area in Southwest Georgia met. Acting director Ann Barton, Ph.D., Area Network Director for the Georgia Department of Human Resources, was appointed civilian coordinator at this meeting. Col. William Hammet was designated as military coordinator and Charles B. Gillespie, M.D., an Albany orthopedic surgeon, became chairman of the Coordinating Committee. Dr. Barton prepared the Ft. Benning plan which was submitted to Washington in September 1972. Final approval from Congress came November 1973, and the program officially was dedicated in May 1974 by Secretary of the Army, Howard "Bo" Callaway.

The Ft. Benning MAST program covers 15 counties in Alabama and 48 in Georgia. Eight Central Regulating Committee sites, supervised by physicians who must approve requests, have been established in Atlanta, Columbus, Macon and Albany, Georgia and Alexander City, Anniston, Opelika and Montgomery, Alabama. The on call member of the Central Regulating Committee either approves or disapproves the proposed flight. If the flight is approved by the physician on call, permission is then given the requesting party to transfer the information to the flight center at Ft. Benning, using the name of the approving officer as the referring agent. The 498th Medical Unit Receiving Officer then processes the information, turning it over to one of the primary crew manning one of the 13 model UH-1-H "Huey" helicopters available. These helicopters can carry three litter and four ambulatory patients (or six all litter or nine all ambulatory), and attain altitudes of 17,000 feet and speeds of approximately 140 miles per hour.

The military provides this service to civilians at no charge. However, the committee did assume the responsibility to provide suitable portable radios that would fit the available space on the helicopters and tie in with the radio systems of those units. These were provided so that the helicopters might communicate with the appropriate emergency agencies and hospitals in the areas served. In Southwest Georgia the committee was aided by Jaycee organizations and other civic groups who held fund-raising drives to collect money to purchase needed equipment. Most all communities readily participated in this project, some to the extent of buying extra equipment as was the case of the Downtown Exchange Club of Albany. That organization purchased a $2,000 portable incubator and presented it to the Ft. Benning MAST Project unit.

Ft. Stewart Unit

The Ft. Stewart MAST program was established in May 1974 and covers the areas of Southeast coastal Georgia, Southeastern South Carolina and Northeastern Florida. The unit of six Huey helicopters is provided by the 3rd Platoon, 498th Medical Company based at Wright Army Airfield. In addition to their basic military training, all of the personnel of the 3rd Platoon have received or are now receiving the EMT-A training provided in Georgia by the area vocational technical education facilities. Upon completion of this training, they are registered with the Department of Human Resources so as to be fully aware of the EMS procedures in Georgia. J. Bruce Barragan is the civilian chairman of the Coordinating Committee and Richard Melenson,



Trained Appling County emergency medical technicians Dave Bruce, Jimmy Swain, Kenneth Perry and Jimmy Woods load a patient into the Army medevac helicopter which can carry three litter and four ambulatory patients at one time. U. S. Army Photograph.

University Hospital in Augusta is the secretary-treasurer.

As of March 10, 1975, the 3rd Platoon had flown 82 MAST missions and had transported over 40 emergency patients and critically needed blood. Hospitals served by Ft. Stewart MAST have found the program to be an important supplement to the existing health care delivery system in Coastal Georgia.

The Fort Jackson, S.C. MAST unit was approved March 17, 1974 and since that time has flown numerous missions including the rescue of three men from a swamp in which their boat had capsized. The area of operation extends only within the boundary of South Carolina, however, hospital transfers and other activities have taken them to Savannah, Augusta and Atlanta. The service is provided by the 4th Platoon, 498th Medical Company based at Columbia Metropolitan Airport and administered by the South Carolina Department of Health and Environmental Control through its Division of Emergency Health Services, the State Highway Patrol, the South Carolina Hospital Association. Col. Lawrence R. Singer is MAST coordinator for Ft. Jackson. All personnel, including pilots, medics and crew chiefs currently are undergoing training in the EMT course given by Carolina Ambulance Inc. to increase their proficiency in emergency medical treatment.

Planning for the fourth MAST program serving Georgia began in March 1972. A group of interested individuals from Southeast Alabama met with Fort Rucker personnel, site of the U.S. Army Aviation School, to discuss the possibilities. The base did not fully qualify as a MAST unit because of its limited capabilities for providing aeromedical evacuation. However, state officials joined the effort and in late 1972 Governor George Wallace allocated $400,000 in revenue sharing funds for the State Emergency Medical Service Radio Network which included the installation of non-military frequency radios in the Ft. Rucker and the Alabama portion of the Ft. Benning operation. Formal application was made in January 1974 and granted on March 1, 1974.

The Air Ambulance Unit (FLATIRON), Lyster Army Hospital, provides Ft. Rucker with the MAST capability which serves approximately 17 counties in Alabama, 7 in Georgia and 15 in Northwest Florida. Actual operation began on June 26, 1974 for the roughly 26,900 square miles and a population of almost 1,400,000 people served.

Ft. Rucker personnel recently reported that of the 57 missions requested by November 1974, only three requests were denied. The weather made one flight impossible and two were not approved because they were considered not to be valid emergencies. The physicians who have utilized MAST flights hold high regard for the program and the unit capabilities, but they also have been made to understand that the services are only supplemental to the already existing emergency medical services system.

Personnel and Equipment Provided

Each MAST site provides two medevac helicopters with pilots and crews available on a 24 hour basis—one primary unit with immediate response and a secondary unit with a 30 minute response. Additional units and crews could be called upon as needed and if available. The helicopters normally will cover an area with a 100-mile radius from the home

bases, including all counties touched by that radius. Limitations of service are due primarily to the fuel capacity of the helicopter as well as operational expense, availability of fuel on the ground, or availability of medical facilities. Consideration is made for overlapping military or conflicting private support. Normally accident site pickups will not be made within 10 miles of cities or towns which have adequate ground ambulance services unless the circumstances are unusual in relation to the rescue mission and accessibility.

The pilot will have ultimate authority to accept or reject a mission, taking many factors into consideration as outlined above. The most significant factor considered so far is that of weather with fuel consideration being the second most important beyond that of appropriateness of the medical needs. Other major considerations particularly as related to night flights have to do with the existence of an approved helipad with lighted wind socks and landing sites in accordance with the FAA regulations.

Air ambulances carry all the medical supplies and equipment usually found on ground ambulances, plus other specialized equipment if needed. Any special equipment must be requested at the time the information regarding the flight is phoned or radioed to the MAST control office. If a hospital sends some of its own equipment with the patient, it will not be the MAST organization's responsibility to return the equipment to its owners. Also, anyone who travels with the patient must make his own arrangements for return transportation.

Typical medical supplies and equipment aboard would be litters and blankets, minor surgery kit, oxygen, splint set, stethoscope, laryngoscope, sphygmomanometer, tourniquet, dressing and bandages, scissors, tape, artificial airways for children and adults. Some MAST programs have the capability of providing a 110 volt electrical current and infant transport isolettes.

Safety Requirements

Safety restrictions demand that only MAST crew will load and unload patients and the helicopter never should be approached from the rear. Participating hospitals are asked to provide suitable areas for the helicopter to land, with a minimum area of 100 feet by 100 feet, which should be free of obstacles such as telephone lines and poles. Helipads that are to be used for multiple or night time flights must be constructed in accordance with suggested FFA guidelines. If no helipad is available, the helicopter will land at the closest airport, with an ambulance and appropriate fire fighting equipment sent there to meet it. The responsibility to provide these ancillary services will be with the requesting agencies. Normally all radio contact with the helicopters will be on the frequency 155.340 unless a request for use of another frequency is made.

Hospitals should have available MAST evacuation linen packs with disposable or non-returnable linens and pillow cases. This should always include a pillow if need be. These packs should contain two sheets, a blanket, pillow and roll of adhesive tape used to hold down the linen around patients being transferred thus preventing damage to helicopter rotators.

Procedures for Accident Evacuation

When the state trooper, sheriff, or local emergency medical service person comes upon the scene of an accident or emergency, he should provide the necessary medical aid as his training allows, contacting an area ambulance if required. If the location or the nature of the accident is such that it would be more expedient for a helicopter to be used, he should call his respective dispatch office and request MAST assistance. Certain information must be provided such as the exact location, local weather, obstacles present, number of patients, types of injuries sustained, and any special equipment needed.

If arrangements have not been made for the patient to be received at a specific hospital, the patient will be taken to the nearest participating hospital having appropriate medical personnel and facilities to handle the patient's problem. This destination will be determined based on the needs of the most critically injured patient. Appropriate radio communications will be maintained between ground personnel and facilities and the helicopters as previously outlined. At the present, missions, except in severe emergency cases, must be approved by the on call member of the Central Regulating Committee for the district in which the accident or illness occurs prior to notifying the 498th Medical Company. This is always applicable for interhospital transfers. This procedure is not carried out in the Ft. Rucker area at this time but will probably be applicable at least in the St. Stewart and Ft. Jackson areas in the near future. The Ft. Rucker Coordinating Committee has not yet chosen to utilize this method of clearing flights but additional consideration is being given to this technique.

Interhospital Transfers

The following information will be required when a patient is to be transferred from one hospital to another: name and telephone number of the individual and hospital requesting the mission; verification that

law enforcement and fire department personnel will be present at both pickup and landing points; names, ages, types and conditions of the patients; accompanying attendants; special equipment needed; name and telephone number of the receiving hospital and physician; landing area, weather and obstacles; radio frequencies to be used, call letters of radio stations at requesting and receiving hospitals.

Medical attendants should accompany patients when the attending physician feels it is necessary. One (rarely two) next of kin also may travel with the patient at his own risk if there is room. Patients should be tagged and appropriate medical records and X-rays always should accompany the patients. Patients will be transferred only to the nearest medical facility where appropriate medical care is available. No transfers will be approved for any reason except medical need. In the past some requests have been made on the basis of pure economic or social reasons and other flights have been requested for the convenience of hospital personnel or laboratory facilities that do not wish to maintain appropriate inventories of medical supplies. These requests will no longer be approved.

The above provides only the highlights of the MAST programs and procedures. For additional information contact:

1. **Ft. Benning**—Ann Barton, Ph.D., Area Network Director, Department of Human Resources, P.O. Box 5262, Columbus, Georgia 31906.

2. **Ft. Stewart**—MAST Project Officer, 3rd Platoon, 498th Medical Company (Air Ambulance), Ft. Stewart, Georgia 31313.

3. **Ft. Jackson**—MAST Project Officer, 4th Platoon, 498th Air Ambulance, Ft. Jackson, Columbia, South Carolina 29207.

4. **Ft. Rucker**—Mr. Thomas G. McCaskie, Southeast Alabama Health Planning Council, P.O. Box 1406, Plaza 2, Dothan, Alabama 36301. ■

MASS EDUCATION PROGRAM TO COMBAT PINWORMS, ROUNDWORMS LAUNCHED

Combatting two major intestinal parasite problems of school-age children, pinworms and roundworms, is the subject of a sound-slide kit which can be borrowed, without charge, by groups of medical professionals and medical and nursing students. Physicians, nurses and health educators may also borrow the slides for showing to schools, parents' groups and other civic organizations.

Prepared by the Roerig Division of Pfizer Pharmaceuticals, the kit of more than 80 slides and a tape cassette is designed as a weapon in a campaign launched by Vivian K. Harlin, M.D., president of the American School Health Association. At the group's recent annual convention, Dr. Harlin, who is also director of health services, Seattle Public Schools, called for "a concerted attack on a problem that could affect as many as one-tenth of the nation's population,* the greater proportion of them children." She added that pinworms might be found to be even more prevalent if adequate screening programs were initiated to detect cases.

Dr. Harlin pointed out that some of the problems of pinworm or roundworm infection may be considered serious, while some are merely troublesome and that "serious" could mean such clinical manifestations as pneumonia, perforated bowel, and bloody or mucous diarrhea. Also, some of the troublesome but less serious problems may be loss of appetite, insomnia, anal itch and irritability.

The president of ASHA also described the impact on a mother, "Shocked to find that her child is infected or re-infected with those ugly crawling things. Then she becomes upset and angry because she has washed, cloroxed, boiled, brushed, vacuumed, air-dried, fumigated, and medicated the child, the clothes, the bedding, the brothers and sisters, and perhaps the cat and dog, only to find that the child is itching and scratching again and that flashlight examination of the anal region at night reveals that the pesky creatures are back again. It's a lot of work for a busy mother to treat for worms, to say nothing of the embarrassment she feels in having the school call this type of infection to her attention."

Beginning with the importance of hand-washing, and trimming the nails rather than biting them, the sound-slide presentation outlines personal hygiene, and housekeeping steps to break the cycle of reinfection. Curing an infected person begins with a simple diagnostic test in which the anal area is swabbed with a scotch tape strip, which is examined under a microscope by a medical professional to detect pinworm eggs. A pleasant, single-dose treatment can then be prescribed by a physician.

To borrow a sound-slide set and obtain quantities of popularly written booklets on treating pinworms and roundworms, medical and nursing professionals and health educators may contact their local Roerig medical service representative or write on their letterhead to Roerig, Pfizer, Inc., 235 East 42nd Street, New York, N.Y. 10017.

* American Public Health Association Report, "Control of Communicable Diseases," statement to press by Warren Lawson, M.D., Minnesota State Health Commissioner, and statement to press by Richard I. Wenzel, M.D. Health Commissioner for Toledo and Lucas County, Ohio.

Six years of effort have produced a coordinated regional system for optimum emergency care.

An EMS System for Metropolitan Atlanta

J. NORMAN BERRY, M.D., F.A.C.P., *Atlanta**

By November 1975 distressed residents and visitors to the Metro area will be able to dial a single widely publicized phone number dedicated solely to handling medical emergencies. The regional medical communicator who answers will immediately contact the closest appropriate EMS resources for care on the scene and during transport to the best suited EMS facility, whether the emergency involves a single person with a heart attack or multiple victims of a mass disaster. This optimum method of resolving medical emergencies now exists to some degree in a few areas within the United States. What will make our system unique is that it will represent the cooperative effort of many local governments, health providers and citizens coordinated by a private agency chartered specifically for this purpose. More than six years of effort has been necessary to bring us to this point; a short history may prove useful to those who have similar goals.

Early Planning

In 1969 the Community Council of Atlanta, with initiative from local physicians and other professionals, undertook the task of identifying priority health needs for the region. One of the greatest deficiencies cited was the lack of a coordinated EMS system.[1] Responding to this need, the health planning agency for the region appointed a Task Force for Emergency Health Services. This consisted of many of those who authored the original report and representatives from the regional medical societies, health providers, and interested citizens. This Task Force enlisted planning help from the Health Systems Research Center (HSRC) at Georgia Tech, and in 1970 published the first comprehensive survey of existing emergency medical resources in the region.[2] This report pointed out many deficiencies existing in the provision of emergency care from the onset of the emergency through so-called definitive care, the most striking of which was the absence of coordination among existing resources.

Intermediate Steps

After the Task Force was reorganized and expanded by the Atlanta Regional Commission (ARC), it was given the specific assignment of developing a regional EMS plan. In the meantime, one of the region's larger counties, DeKalb, was developing its own plan, supported by a grant from the Georgia Regional Medical Program (GRMP). This was patterned after the Jacksonville system, and became operational in May, 1973. It has proved to be highly effective and is supported by county taxation. It was the opinion of the Task Force, however, that all regional EMS providers who intended to conform to reasonable standards should be integrated into the system and offered aid in communications and EMT training. These and many other policy recommendations covering all components of the regional EMS system were adopted as ARC policy by unanimous resolution in March, 1973.[3] Meanwhile the HSRC was working jointly with the Task Force in developing a specific operational plan for an improved system. This plan, supported by a GRMP grant, was completed in April, 1973 and approved by the Task Force.[4]

Final Planning and Implementation

The policy and the operating plan were approved, but selection of the operating agency remained. After a thorough review of all existing agencies, none was deemed adequate for the task. Each of these had primary goals other than EMS coordination. Accordingly, a separate agency was chartered for this specific purpose in February, 1974. Known as the

* 6500 Vernon Woods Drive, N.E., Atlanta, Ga. 30328. Dr. Berry is a member of MAG's Committee on Emergency Medical Services and serves as chairman of the EMS Advisory Council to the Metropolitan Emergency Medical Services, Inc.

Metropolitan Emergency Medical Services, Inc. (MEMS), its board of directors consists of seven persons: One each representing the three largest medical societies; one representing the regional EMS advisory council; one representing the Atlanta district of the Georgia Hospital Association; one appointed by the ARC, and one selected by the other members. At present four of the members are physicians and three are laymen. This board has established policy for implementing the coordinated regional system. Its staff is now developing working agreements among the EMS providers throughout the six counties which will be original participants. The regional communications center will be located in a 29-story tower in the hub of the area and will coordinate EMS telephone, radio, and telemetry activities. The previous EMS Task Forces have been reorganized into an EMS advisory council in order to update EMS standards for the region. This council will recommend regional plans for handling special problems such as poisoning, burns, spinal cord injuries, and early coronary care. It will continue to revise the regional medical disaster plan based upon central coordination of communications and resources.

Acknowledgements

No plan of this magnitude could become reality without broad-based support. The following deserve special commendation:

1. The citizens of Clayton, Cobb, DeKalb, Douglas, Fulton and Rockdale counties, who have voted a 15-cent per capita yearly subsidy toward the operation of the system.

2. The Georgia Regional Medical Program, for consistent support of the regional EMS concept, including grants for the DeKalb county and regional plans. In addition, GRMP has funded a plan for improving EMS services at the Hartsfield International Airport which is now being implemented.

3. The Health Systems Research Center of Georgia Tech, for early and continued support of the EMS system through invaluable research and technical aid, and for final development of the operational regional EMS plan.

4. The Atlanta Regional Commission, for moral and staff support well beyond required limits.

5. The Robert Wood Johnson Foundation, for support including a sizeable grant for implementing the regional EMS communications network.

6. The Department of Health, Education and Welfare, for funding the initial operation of the entire regional EMS system.

7. The many professional and lay members of the EMS Task Forces who have contributed their time and talents selflessly. ■

REFERENCES

1. Task Force Reports, Federal grant application for MACLOG, Atlanta; June, 1970.
2. Berry, J. N., DeLon, G. and Newmark, L.: EMS Survey Report to MACHEALTH, Atlanta; February, 1970.
3. Resolution Adopting EMS Task Force Guidelines, Atlanta Regional Commission; March, 1973.
4. An Improved Emergency Medical System for Metropolitan Atlanta, Georgia Tech Health Systems Research Center; April, 1973.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL
March 9, 1975

Drug Utilization Guidelines: Adopted a report from the Peer Review Committee that establishes guidelines for drug utilization control to be used by CHAMPUS. These will be evaluated after six months use.

Professional Liability Insurance: Received a report from the Committee on Legislation that described four bills that have been submitted to the Georgia Senate in an attempt to find legislative solutions for the increasing professional liability insurance problems.

Membership Opinion Poll on PSRO: As of Friday, March 7, there had been 2,261 responses—over 50 per cent of the membership.

National Health Service Corps Physician: Endorsed Hall County Medical Society's approval of a NHSC physician for Cleveland in White County.

Committee on Education: Approved the appointment of a Subcommittee on Public Education.

CHAMPUS: Received a report that in the future MEDICARE criteria is to be applied to CHAMPUS data. This may result in a 20 per cent fee reduction.

Concurrent Review Data Collection: Approved the concept that MAG should develop and use its own medical care evaluation data system for the single concurrent review program now being developed.

Criteria Development for Hospital Utilization Review: Reviewed the revisions in the admission criteria and agreed that they now were an acceptable base for the conduct of utilization review in hospitals.

National Health Planning Act of 1974: Received a report on the development of the Health Service Areas in Georgia as called for by this act. It was stated that every attempt has been made to involve as many physicians as possible in the designation of these HSAs. The designation must be made by the Governor by July 4. It was urged that members attend the HSQ meeting held in each area.

SEER: Received a report that 34 hospitals have approved the SEER program.

The author outlines the philosophy and specifics of emergency treatment in his institution.

Shock Team Approach to Resuscitation

PETER ROSEN, M.D., *Chicago, Illinois

To anyone who has had responsibility for management of a busy emergency department, it becomes clear that the decision-making and response to the acute emergency are different than what is conventionally learned in inpatient medicine,[2, 3, 6, 8]

First, one must react rather than act, and usually on little, inaccurate, or no information.

Second, an instantaneous decision must be made about the level of physiologic derangement. Critical here is system pathophysiology rather than organ. The proper question to be asked is: "What life-threats need to be dealt with?", not "what is the diagnosis?"

Once stabilization is achieved, then and only then does it become meaningful to ask specific questions leading to a specific label.

In studying the errors in our resuscitative techniques, we have concluded that where we were failing was in our initial approach to the patient. We then evolved the shock team approach. We make no claim for originality since I'm sure similar techniques are used elsewhere, but feel it might be profitable to share our experiences.[2, 3, 8]

As it is presently staffed, our shock team consists of two residents, one intern, one nurse, and one emergency technician. Obviously, not every emergency department is as well staffed; and the team can be made workable with fewer members.

The first principle is to know who is on the team. We make a daily assignment, and when the shift changes it is team captain's responsibilty to know who the new nurse, intern, etc., are.

The second principle is that the team captain will function as overseer. If he becomes involved in a specific chore (e.g., intubation or insertion of a chest tube) he must delegate the overseer duties to another member of the team. There can be only one team captain, and he must be aggressive in his control of the resuscitation. Major trauma and cardiac arrest invariably produces a wealth of onlookers. These must be removed from the area if resuscitation is to occur smoothly. The team captain must control the environment. He also is the spine upon which logical therapy commences and sustains.

Principle 3. The team must function as a unit. This requires practice and a strong team captain. We summon the trauma team by ringing a bell which rings throughout the emergency department. We then insist on a full resuscitation being carried out before any diagnostic procedures. It is an extremely common occurrence for very serious injuries to be dismissed as trivial on initial examination.

Each member of the team has specific duties relating to our trauma protocol (see Table 1), and it has taken much practice to work these out. This is a continuing process, as by the time we have one group trained, we rotate and start a new group of physicians.

Step 1: Getting the Patient to the Shock Room and Summoning Team.

This is no trivial problem. Ambulance drivers are frequently more concerned with retrieval of their stretchers than the welfare of their patients. On more than one occasion, they have announced a "dead on arrival" in a patient who was fully resuscitable.

The technicians who perform our initial triage usually become aware of the case first. They, therefore, are the ones to push the trauma bell and to assist the ambulance personnel into the transfer to shockroom stretcher.

* Director and professor of the Division of Emergency Medicine, University of Chicago Hospital and Clinic, 950 East 59th Street, Chicago, Ill. 60637. Dr. Rosen presented this paper in Atlanta at the December 1974 meeting on "Stabilizing the Emergency Patient," sponsored by the Medical Association of Georgia, the Georgia Chapter of the American College of Emergency Physicians and the Georgia Society for the Prevention of Blindness.

Step 2: The Patient's Airway.

Doctors know how important the airway is, but moving from knowledge to action requires practice.[6] We have made video tapes of resuscitations and it is amazing how long the airway is neglected. It is now standing order to apply nasal cannula and full volume O_2 flow immediately. We accept the risk of the emphysematous patient as our trauma captains are prepared to breathe for the patient, if necessary. By this time the team is on the scene and under control of the captain.

The following steps are not sequential but parallel, thus the need for teamwork:

Step 3: Undress the Patient.

This should be complete. If necessary, clothing should be cut away. We have seen patients thrown into profound shock by sitting or standing them to remove a tee shirt or a pair of pants. Once the patient is nude, they should be covered with a sheet for warmth and modesty. It is surprising how much severely injured patients are aware of their surroundings.

Step 4: Obtain Blood Pressure and Pulse.

These are acquired by the nurse in the left arm, if possible. She immediately reports them loudly to the captain.

Step 5: Start a CVP Line.[4]

This is done in the right arm by the intern. If successful, he immediately takes and reports a CVP to captain.

During these steps, the captain is managing the airway. If the patient is able to breathe unassisted, he will do no more than support with O_2. But, he is ready to intervene immediately with mechanical assistance for respiration and subsequent intubation. Muscle relaxants are used liberally and readily when necessary.[6]

Should he opt for these, he makes the intern the team captain until the procedure is finished. Simultaneously, the nurse and/or technician start a second conventional large-bore I.V. in the left arm. If more lines are needed, they can then be added.[1, 9]

The only alteration in this procedure for the cardiac arrest team is that the initial determination of absent pulse and coma would have produced a closed chest massage, as well as airway management.[6]

At this point in the resuscitation, which even in unskilled hands should have taken no more than 10 minutes and ideally 2-5, the captain can stop and assess extent of injury. He can delegate this, or quickly perform the examination himself.

He will then make a decision about the necessity for Foley catheterization, nasogastric intubation, thoracostomy, paracentesis, or pericardiocentesis.

TABLE 1
TRAUMA PATIENTS

1. Disrobe completely, also immediate blood pressure and pulse. If status of spine not known, cut clothing away.
2. Airway
   a. Oral airway
   b. Ambu bag
   c. O_2—open wide
   d. Endotracheal equipment at direction of trauma captain
      1. laryngoscope
      2. E T tubes
      3. Procaine 2 percent, 3 cc. for transtracheal injection
      4. Succinyl choline, 40 mg. at discretion of trauma captain
3. I.V.'s
   a. Lactate ringers only.
   b. #14 intracath for CVP.
      #14 intracath.
   c. Subclavian line at request of trauma captain.
   d. Internal jugular line at request of trauma captain.
4. Open wounds to be bandaged at direction of trauma captain.
5. Fractures to be splinted at direction of trauma captain.
6. Consultations, x-rays, EKG, and laboratory at discretion of trauma captain. No Diagnostic X-rays or EKG until patient's condition is well stabilized!!!
7. Tetanus Toxoid, ½ cc. IM—all patients.
   a. On minor trauma, no toxoid if booster within 12 months.
   b. On major trauma, all patients to receive booster. Human antitetanus antitoxin, 500 u. IM if no good history of prior tetanus immunization.
8. For all penetrating thoracic and abdominal trauma, antibiotics to be started as follows:
   Thoracic: 1,000,000 u. penicillin I.V. pint bottle, and 250,000 each following bottle; ½ gram streptomycin IM. If penicillin allergy, Cleosin 4 cc. I.V.
   Abdominal: 1 gm. Kanamycin, first I.V. bottle and 250 mg. each following bottle, but no more than 2 gm. to be given in emergency room. Give 4 cc. Cleosin I.V. in first bottle.

For all patients in shock, i.e., blood pressure less than 100/60, pulse greater than 100 and clinical signs of diaphoresis, cold clammy skin, weak pulse pressure, and apathy to surroundings.

1. Foley catheter.
2. Chest tube #38 Fr. inserted in R, L, or both 5th intercostal spaces in anterior axillary line at discretion of trauma captain.
3. N-G tube at discretion of trauma captain.
4. Type and cross match 6 units of whole blood.
5. Stat CBC, electrolytes, and blood gases.
6. One Amp $NaHCO_3$ I.V. push—additional at discretion of trauma captain.
7. Abdominal paracentesis at discretion of trauma captain.

[2, 3, 5, 8] By now, blood will also have been drawn for type and cross match. If the situation is critical enough, we recommend type-specific but unmatched blood. We prefer not to use O (–) blood.

By now, the patient should have commenced a response to resuscitation. If there are injuries suggestive and a lack of response to therapy, pericardial tamponade is considered, and pericardiocentesis performed.[2, 3]

By now, too, the specialty teams have been summoned and the operating room readied. If necessary, surgery can be performed in the emergency department. This is rarely the case. Injuries that survive long enough to reach the emergency department can almost always reach the operating room.

The remainder of our protocol is included for information. It is not the only approach but it works well in our Emergency Department. Many would argue over the lack of diagnostic steps in our approach. We have seen too many deaths ensue from efforts to diagnose, when active intervention was needed.

We feel that it is not possible to overuse the shock team approach. One can always remove a CVP line of shut off the O_2.

Summary

A team approach for the stabilization of life-threatening pathophysiology is recommended. Once stabilization has been achieved, more conventional diagnosis and therapy can be introduced. ■

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TABLE 2

ABDOMINAL STAB WOUND PROTOCOL

1. Observe trauma protocol
2. If patient shocky at any time, or if obvious peritoneal penetration (e.g. bowel or omentum eviseration or signs of peritonitis) all these patients must be explored in the operating room. If patient financially ineligible, admission must be mandatory.
3. The remaining stab wounds will be handled as follows:
   In the emergency room the wound will be prepped and sterilely draped. Under local anesthesia the stab wound will be enlarged, and explored.
   a. If the fascia is penetrated the procedure will be terminated, the wound packed open, and the patient explored in the operating room. Admission will be mandatory if the patient is financially ineligible.
   b. If there is no fascial penetration, the wound will be closed primarily and if no other indication for admission, the patient will be discharged.
4. Tetanus prophylaxis will be carried out. (See Tetanus Protocol.)
5. Under no circumstances is the stab wound to be probed.

TABLE 3

DIAGNOSIS PARACENTESIS PROTOCOL

Abdominal trauma (any injury below a line drawn through the nipples).
A. Gunshot wound—mandatory exploration
B. Stab wounds
   1. Peritoneal signs—exploration
   2. No peritoneal signs:
      Explore wound locally
      a. penetration of fascia—explore in operating room
      b. no penetration—observe or discharge
C. Blunt trauma
   1. Conscious patient with no abdominal signs—observe or discharge
   2. Conscious patient with abdominal signs—explore or observe (if questionable bruise of abdominal wall)
   3. Comatose, inebriated patients with abdominal signs—explore in operating room
   4. Comatose or inebriated patients with no peritonal signs or equivocal signs:
      Abdominal paracentesis
      a. peritoneal dialysis catheter inserted in line below umbilicus. 1 liter lactated Ringer's RUN in (500 cc. in children) 1 liter, then RUN out.
      b. if return grossly bloody, explore in operating room.
      c. if fluid clear or pink, then do following: RBC, WBC, Amylase.
      d. if RBC $>$ 100,000/mm^3—explore in operating room.
         if RBC $<$ 100,000/mm^3—observe (repeat paracentesis if indicated).
      e. if WBC $>$ 100/mm^3, explore in operating room.
      f. if Amylase $>$ 100μ/100ml, explore in operating room.

All patients who undergo paracentesis with dialysis catheter are admitted for observation, if paracentesis is negative.

Saving the life and limb of the Georgia snakebite victim is the object of this paper which presents updated information on proper treatment.

Poisonous Snakebites in Georgia

JONATHAN M. BRYANT *and* MILTON F. BRYANT, M.D., *Atlanta**

THE ADVANCES IN THE TREATMENT of snakebite during the past 10 years emphasize the need for the practicing physician to continually update his information and keep abreast of new developments.

It has been estimated that five to eight thousand individuals are bitten by various poisonous snakes in the United States each year.[1, 2] The actual mortality rate is difficult to document but it would appear that the mortality rate is in the neighborhood of 1-3 per cent.[3] Not fully appreciated is the fact that children are frequently victims of poisonous snakebites. The fatality rate is higher in children since mortality rate is related to size (all other factors being equal).

The morbidity rate is not definitely known but all reports indicate that it is too high—30-50 per cent.[4] Tissue necrosis with impairment of muscle, tendon, nerve and joint function, loss of fingers, hands, arms and legs through amputation is not uncommon. Proper early treatment can reduce the mortality and morbidity rates.

Poisonous snakes are found in every state except Maine, Alaska and Hawaii. Snakebite accidents occur more frequently in the southern part of the United States where the climate is warm and the snake population is large. The sudden, explosive occurrence of a snakebite can bring the victim and the physician to the brink of catastrophe. Frequently these emergencies are presented to physicians who are unfamiliar with and poorly prepared to handle the emergency measures that must be promptly carried out. Snakes remain mysterious and terrifying creatures to the great majority of Americans and frequently a considerable element of hysteria may affect the victim and those around him.

The following annual mortality data for snakebites in Georgia is presented to show that deaths from snakebites are a reality in our state. This data in Table 1 was "pulled out" of death certificate information by the Division of Physical Health of the Department of Human Resources and it is known that some deaths were missed. Unfortunately there are no official surveillance records for snakebite morbidity or mortality in our state. In addition we do not know which types of snakes caused these deaths. The total number of victims bitten by snakes each year in Georgia is not known but it is estimated to be between 100 and 300.

TABLE 1
SNAKE BITE DEATHS IN GEORGIA
1960-1973

1960	2	South Carolina and Cook County
1961	3	Colquitt, Effingham and Butts County
1962	2	Green and Fulton County
1963	2	Hall and Haralson County
1964	2	South Carolina and Clinch County
1965	1	Gordon County
1966	1	Decatur County
1967	–	
1968	2	Ben Hill and Camden County
1969	1	Green County
1970	1	Stephens County
1971	3	Thomas, Pierce and Troup County
1972	2	Tift and Ben Hill County
1973	2	Chatham and Gordon County

Varieties of Poisonous Snakes

There are two families of poisonous snakes native to Georgia—the pit viper family (Crotalidae) and the Elapidae family (coral snake). The pit viper family includes the rattlesnake, moccasin and copperhead.

RATTLESNAKE

The eastern diamond-back rattlesnake is the largest poisonous snake in the United States and one of the most common poisonous snakes in Georgia. The large rattle, diamond-shaped blotches edged

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with yellow covering its body and large fangs help to identify this snake. Giant diamond-backs may reach eight feet in length and weigh 15-25 pounds. These monsters produce enough poison to kill a hippopotamus. The pygmy rattlesnake is identified by its small size (smallest pit viper in U.S.) and tiny rattle at the end of the tail. In spite of its size the toxin is potent and potentially lethal.[5] When startled the animal vibrates and its rattle produces a high pitched sound frequently inaudible to the human ear, but when audible it sounds like an insect buzz. The fangs are so small that they are not easily discernible without a magnifying glass. The timber rattlesnake is also found in Georgia.

The pit vipers are responsible for about 98 per cent of all poisonous snakebites in the United States. All of the pit vipers are distinguished by a facial pit between the eye and nostril—heat-sensor organ. Rattlesnakes are born alive and are venomous from birth. Snakes are relatively simple animals and their bites are instinctive and not premeditated. They are quick to strike and frequently prowl at night. Mice, lizards, frogs, birds, rabbits and chipmunks make up some of their favorite foods. Being cold blooded they use their heat sensitive locators to strike an animal much as a heat sensitive missile zeroes in on its target.

MOCCASIN

The water moccasin is also called a moccasin snake or cottonmouth. It has a hollow or pit on the side of the head in front and below the level of the eye. The snake has a broad head, a rather fat body with large olive-colored bands and is usually 3½-5 feet in length. Various harmless, water-loving snakes may have an appearance similar to the moccasin but none of the non-poisonous snakes have fangs or the pit. It tends to inhabit swampy areas and other watery places such as the banks of streams and lake shores. The bite of a water moccasin is highly dangerous and the treatment is the same as for any pit viper bite.

COPPERHEAD

The copperhead is poisonous and is a pit viper. It is also known as the pilot snake, red adder and the red eye snake. Its body has broad chestnut-red bands between coppery-red bands. Most copperheads are between 2¼-4 feet in length. The copperhead, like the moccasin, does not have a rattle on the tip of its tail. It has a pit in front of and below its eyes and a nostril in front of the pit. The copperhead is quiet, beautifully camouflaged, and frequently bites people. Serious poisoning may ensue. The treatment of copperhead bites is the same as for rattlesnake and moccasin bites.

PIT VIPER VENOM

The venom of pit vipers is injected into victims through hollow fangs that may be 3-4 cm. long. These fangs have been referred to as nature's hypodermic needles. The venom is activated by the pH and temperature of muscle and fatty tissue. A host of destructive enzymes are released such as proteases, esterases, cholinesterases and hemolysins. These enzymes destroy the surrounding tissues, disrupt the blood vessels and dissolve the interstitial tissues. Secondary toxic protein hydrolysates, including bradykinin, are formed and these toxic products along with the venom are absorbed into the vascular compartment and distributed systemically. Blood and tissue fluid release causes rapid swelling and distention of the tissues. If these reactions occur beneath the fascia, a closed fascial compartment syndrome may occur with further necrosis of soft tissue. Rapid swelling, ecchymosis and excruciating pain at the bite site occurs early. Eventually anesthesia and local paralysis occur as tissue necrosis proceeds. A pale blue discoloration with petechiae and ecchymotic blotches is seen around the fang marks. Erythema almost never occurs. Absorption of the toxin and tissue products leads to systemic symptoms; nausea and vomiting, bradycardia or tachycardia, hypotension, severe anemia, convulsion, delirium, coma and death. If large quantities of toxin and/or poisonous tissue products gain entrance into the vascular compartment death may ensue within 24 hours.

The venom is produced as a feeding mechanism —not for defensive purposes. After killing a "proposed meal" the prey is ingested whole and the injected venom helps to complete the digestion. Pit viper venom has been described as being a digestive and hemorrhagic toxin which possesses a potent spreading factor. It would seem logical to simply state that the pit viper toxin has a destructive, digestive action on all tissues.

Digestive action after systemic absorption may result in a variety of pathological findings from destruction of tissue in and outside the vascular tree. Hemorrhage into the subcutaneous tissue, retinae, pleural spaces, and peritoneum may occur along with hemorrhage into any organ. Neurologic features include fasciculation, severe generalized weakness, focal paralyses, convulsions and coma. Shock and renal, hepatic and/or myocardial failure may occur prior to death.

More people in the world die from snakebite than from all other animal bites combined. Ninety-

eight per cent of all bites are located in the extremities and total or partial loss of an extremity (or loss of function of any part on an extremity) is the usual criteria that we must consider in determining whether or not our treatment has been successful. Most victims are presented to the physician within the first hour following a poisonous snakebite. Signs and symptoms will vary depending upon the amount of venom that has been injected, depth of injection and the amount that has been absorbed systemically.

Symptoms

In general there is no question about the fact that the victim has been bitten by a poisonous snake. Usually the victim or companion knows the type snake that has inflicted the bite. Often the snake (hopefully dead) is brought to the emergency room with the victim. Occasionally individuals are bitten by non-poisonous snakes, spiders or scorpions and they may be confused as to what has bitten them. Careful questioning will usually solve the issue.

Pain and swelling of the envenomated limb is usually the presenting symptom. Fang marks must be present if the bite was produced by a poisonous snake. As mentioned, the fang marks are usually surrounded by a bluish-white discoloration and petechiae and ecchymotic blotches develop rapidly. Weakness, nausea and vomiting, dizziness, tingling, numbness and blurring of vision often occur early. As the time lag increases, marked edema of the involved extremity occurs. Neglected victims present with shock, blood-tinged excretion from all body orifices, convulsions, coma and death.

Treatment

It is obvious that the appropriate treatment must be administered immediately and directed toward retrieving the venom, limiting the spread of the venom, preventing local tissue damage and neutralizing the toxin that has been deposited in the tissues.

Many articles have been written about immediate first-aid treatment administered by the victim or companion. While one cannot deny that immediate judicious first-aid may be helpful, the main objective one must keep in mind is *get the patient to a hospital and a doctor as soon as possible.* Considerable valuable time may be lost by trying to make inadequate incisions, applying suction, application of a tourniquet that is too tight and trying to cool the extremity. Most of the time it is best to simply wash the bite area, splint the extremity, keep body muscular activity to a minimum and transport the victim to a hospital quickly. A reassuring attitude on the part of the first-aider is very helpful.

Emergency Treatment

The operating room should be alerted so that immediate preparation for surgery can be made.

1. Look for fang marks—non-poisonous snakes do not have fangs.

2. Trying to grade snakebites as to severity is fraught with danger and should be abandoned. It is impossible immediately following a snakebite to determine the quantity of toxin injected or the depth of injection. All bites must be assumed to be lethal to the local tissues and to the individual.

3. Have the nurse wash the site of the bite so as to remove any toxin that may be on the skin surface. Lightly apply a broad tourniquet proximal to the wound.

4. Start an IV in an uninvolved extremity with a needle large enough to administer blood. Blood for typing and cross matching should be obtained stat and 3-4 units of blood requested. After systemic absorption of the toxin has occurred hemolysis may ensue making cross match determination difficult or impossible. A complete blood count should be obtained.

5. Skin testing for antivenin should be done. Keep a syringe of adrenalin loaded and with the patient at all times in case of anaphylaxis.

6. 1000 mg of hydrocortisone should be given intravenously. This does not interfere with the antigen-antibody reaction between the venom and antivenin. One gram of hydrocortisone should be given every 6 hours for approximately 72 hours.

7. Ten vials of Wyeth's Polyvalent Antivenin is added to 250-500 cc of saline and infused over a 1-2 hour period. Another 10 vials should then be slowly infused during the next 24 hours. Do not give the antivenin locally or intramuscularly. Intra-arterial infusion in the involved extremity has been suggested but we do not believe this route is necessary or practical. If reaction to the antivenin occurs it can be immediately discontinued and adrenalin given intravenously. It has been estimated that 3 mg. of venom is neutralized by 1 cc of antivenin. A large rattlesnake may deposit 300-400 mg of venom in the tissues.

8. Broad spectrum antibiotics should be given. Actually venom is bacteriocidal; however, resultant tissue necrosis may provide an excellent culture media for bacteria that gain entrance to the area.

9. Tetanus prophylaxis should be given. Antihistamines seem to have a synergistic action with venom and should not be given.

10. If possible obtain consultation and help from one or two other physicians. From a medical-legal standpoint this is most important.

11. Take the patient to the operating room and obtain consultation with the anesthesiologist. Jointly the team can decide upon the anesthetic of choice. Nerve block, axillary block, spinal anesthesia or general anesthesia are all acceptable depending upon the circumstances. Provided the patient's general condition is stable, the use of general anesthesia may save time.

12. Do not use a tight tourniquet as a bolus of venom and digested protein material may be suddenly released into the systemic circulation after deflation of the tourniquet. Do not intermittently release the tourniquet as this seems to serve as a pumping action for absorption of venom.

13. Excise the bite by making elliptical incisions 2.5-4 cm. from the margin of each fang mark. Incision and suction is not as effective as excising the wound in retrieving the venom.[6] Experiments have shown that 79 per cent of tagged venom can be removed if excision is carried out within one to two hours following envenomation. The plug of tissue should be removed to the level of the underlying fascia.[6] The fascia should always be widely opened. If no venom has been deposited subfascially, no harm is done by opening the fascia. If toxin has been injected subfascially, opening the fascia is most important.[4] All green, edematous, necrotic tissue should be debrided and the wound irrigated with copious quantities of saline. In delayed cases a formal fascial compartment decompression should be carried out.

14. The wound is lightly packed open with gauze soaked in betadine. Secondary closure or skin grafting can be carried out 5-7 days later.

15. Insert a Foley catheter and check the urine hourly for volume and blood.

16. Use appropriate measures to combat shock —blood volume replacement.

17. Patient should be placed in the intensive care unit and one should be prepared to maintain respirations and blood pressure if these problems arise.

CORAL SNAKES

The coral snakes belong to the Elapidae family of reptiles. The fangs are anatomically different from the pit viper's fangs. The coral snake's fangs are not hollow but have grooves so that venom flows down the grooves to gain entrance into the tissues. The snakes are small (12-18 inches in length), have small round black eyes, are waxy-shiny in appearance and have a black head. The fangs are fixed and usually these snakes hold and chew their victims so as to allow the toxin to enter the wound. The coloration is manifested by alternating bands of red, yellow and black. The narrow yellow ring is between a broad red ring and a broad black ring. The colored rings encircle the ventral side. A black or melanotic form and a white or albino form may occasionally be seen. The harmless scarlet king snake has a red snout and its color pattern is similar to but different in color band arrangement than the coral snake. These bands have given rise to many jingles such as "Red touching yellow will kill a fellow," "Black head means dead," "Red touching black venom he doth lack."

The coral snake venom is neurotoxic and there is usually some pain and swelling at the site of the bite. This fact leads to a false sense of security in that symptoms are frequently delayed until systemic absorption occurs.

The signs and symptoms of generalized weakness, nausea and vomiting, dizziness, various cranial and/or peripheral nerve palsies. A bulbar type paralysis then ensues with involvement of the cranial nerves and the respiratory center. The treatment is the same as outlined for bites by the pit vipers. Five to six vials of coral antivenin should be given intravenously over a one to two hour period followed by another 5-6 vials given slowly during the next 24 hours. One should be prepared to mechanically maintain respiration.

Antivenin for use in victims with pit viper and coral snake bites is made from hyperimmune horse serum. (Wyeth Polyvalent Antivenin for pit vipers and Wyeth antivenin for use against North American coral snakes.) The pit viper antivenin is effective against all North and South American pit vipers. Coral snake antivenin is not effective against the Arizona (Sonora) coral snake. These antivenins are available at most hospitals. Antivenin may also be obtained from poison control centers and from the state health department (Department of Human Resources). In addition, the U.S. Center for Disease Control has a large supply of various antivenins.

The reptile house at the Atlanta Zoo is probably its major attraction. Personnel at the Atlanta Zoo are very knowledgable about snakes and the treatment of snakebites. A large quantity and variety of antivenins is kept on hand. One can obtain help by telephoning the Atlanta Zoo or calling Mr. Howard Hunt (298-8905) or Mr. Howard Lawler (627-7609) at their homes.

Anaphylatic reaction to antivenin is similar to any horse serum anaphylaxis. The I.V. must be stopped and adrenalin given through the I.V. tubing. Delayed reactions or serum sickness reactions occur frequently and are manifested several days and up

to three to four weeks following infusion. Fever, weakness, lymphadenopathy, joint pain, hives and various neurological signs may occur. Cortisone is the treatment of choice. Antivenin against pit viper bites made from goat antiserum and human antiserum can be obtained from the U.C.L.A. School of Medicine.

For immediate information as to the availability and nearest location of various antivenins a physician may contact the Antivenin Index Center of Zoological Parks and Aquariums in Oklahoma City by calling (405) 271-5454.

Summary

Poisonous snakebites in Georgia are common and must be treated promptly. The life and limb of the patient are in danger and treatment concepts are changing. The age, size, general health of the victim, type of snake, amount of envenomation, depth of envenomation, elapsed time, site of bite, type of first-aid treatment and type of definitive treatment given all play a part in determining the final outcome. A suggested plan of action following bites by poisonous snakes indigenous to Georgia is outlined. ■

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THE 1975 YEARBOOK

The 1975 Yearbook of the Medical Association of Georgia will be mailed to you with the August issue of the *Journal,* if you are an active member. If information concerning your name, address or specialty has been inaccurate in past rosters, and you have not corrected it with this office in the past year, please fill out and send in the coupon below. If you have recently changed address, or plan to do so within the next few months, you may wish to supply us with the new address for the 1975 Yearbook.

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DR. CURRY TO HEAD EMORY'S PHYSICIAN ASSOCIATE PROGRAM

Dr. Robert H. Curry has been appointed director of the Emory University Physician Associate Program effective April 1.

He comes here from Birmingham, Ala., where he has served as clinical director of the Physician Assistant Program, Department of Medicine, University of Alabama for the past year.

Dr. Curry, 31, has the B.A. from Emory and the M.D. from the University of Miami. He was named Best Teaching Intern at the University of Alabama Hospitals and Clinics for 1970-71.

Dr. Curry's appointment was announced by Randall W. Carter, director, Division of Allied Health Professions, Emory School of Medicine, which supervises the Emory Physician Associate Program.

Dr. Curry replaces Dr. Robert E. Jewett who left Emory to become first dean of the new East Tennessee State University College of Medicine in Johnson City.

MACON CONTINUING MEDICAL EDUCATION WORKSHOP SCHEDULED

In what promises to be a unique opportunity for hospital-based medical educators to share experiences, ideas, and methods, the Medical Association of Georgia will sponsor a workshop on continuing medical education at the Medical Center of Central Georgia in Macon on Saturday, April 26. Under the direction of James L. Achord, M.D., the workshop is intended primarily for directors of medical education (DMEs) and other persons responsible for the continuing medical education of physicians in their hospitals. There will be no registration fee.

Topics treated in the workshop will be the definition of continuing medical education (CME), the use of medical audit for assessing educational needs, the Medical College of Georgia's CME Programs and resources, and the future of CME. Interested hospital-based educators should contact either of the following persons:

James L. Achord, M.D.
Medical Center of Central Georgia
777 Hemlock Street
Hospital Box #146
Macon, Georgia 31208
Tel.: (912)-742-1122

or

Stephen L. Daniel, Ph.D.
Medical Association of Georgia
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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

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Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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The Newest Specialty: Emergency Medicine

TRADITIONALLY THE MEDICAL SPECIALTIES have developed because of increased knowledge or new techniques in a particular field. Emergency Medicine is unique in the fact that its evolution can be traced directly to consumer demand; by nature it is a consumer-oriented specialty.

The increased mobility of American families, the shortage of primary care physicians, and the virtual disappearance of the "family doctor" contributed to a tremendous increase in utilization of the hospital emergency department as the primary care facility. Suddenly interns were confronted with large numbers of cases covering the entire spectrum of medical science. Fully-trained physicians were hired to become emergency department directors and physicians, and a new specialty was born.

The American College of Emergency Physicians was formed in 1968 to promote the specialty and to provide educational forums. At present ACEP has over 5,000 members. There is an active Georgia chapter with over 60 members. Emergency medicine residencies have been developed, and board certification is imminent. Overall, Emergency Medicine is beginning to give the appearance and to take on the responsibilities of a specialty.

When one becomes an emergency physician, the emergency department becomes his whole professional life instead of a moonlighting job; he is responsible not only for maintaining but also for improving emergency care. As a result of this we have seen many new developments in the field. Most prominent is the rescue squad. Less obvious improvements have been the emergency medical technician/paramedic training programs and new methods of handling increasing patient loads.

Emergency Medicine has been referred to as a "30 minute specialty"; the emergency physician must be able to manage the first 30 minutes of any illness. He does not have to know how to maintain a diabetic on insulin, but he must be able to recognize diabetic shock or coma. He must also know how a diabetic with an emergency illness or trauma should be treated. He must consult with the physician and patient community so that he can organize his department toward meeting their needs.

The emergency physician must also be the team leader in the emergency department, directing the training of his co-workers so that they perform as a team. Without this close cooperation the department can never operate efficiently; and efficiency is the byword of a busy emergency department.

Built-in Peer Review

An important strength of the Emergency Medicine specialty is its peer review system. Each patient seen by the emergency physician will be referred to a private physician who will have a record of the emergency physician's examination and treatment and will be able to examine the patient and eval-

uate the results. The unqualified physician will be quickly detected. No other specialty has such a review system.

The men who are becoming emergency physicians are generally young physicians just out of training. They find the pace and variety of medical problems challenging, and they respond to the challenge by seeking continuing educational programs tailored to their needs. These programs are just now becoming readily available; but more intensive programs are needed to train the emergency physician so that he can meet the needs of the emergency department and prepare himself for board certification. ACEP pointed out this need by its recent publication of an outline of the skills required of an emergency physician. ACEP is also making available a self-assessment exam to provide comparison of emergency physicians throughout the country, including those who have completed residencies.

Actual in-depth training programs, however, are not readily available. This is the greatest need in the specialty. It is not enough to leave each physician to seek his own training. This gap must be filled by isolated groups of emergency physicians, the state chapters of ACEP, and ACEP itself. Medical colleges, state medical societies, and teaching hospitals must also share the burden.

The capable emergency physician is an asset to any hospital emergency department. The need is well-documented. The training and education of physicians to meet this need is improving each year. Patient, medical staff, and administration acceptance of the emergency physician are generally excellent. These factors combine to provide the birth and growth of a truly exciting specialty—Emergency Medicine!

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Ophthalmology, Optometry and the Law

DURING THE 1975 SESSION of the General Assembly a bill of profound importance to the public, the medical profession, and the state was introduced in the Georgia House of Representatives. This bill, H.B. 88, was sponsored by The Georgia Optometric Association and introduced by Rep. Ward Edwards of Butler, Georgia. This exact bill or one similar to it has been introduced seven times during the past nine years and has been strongly promoted by the optometrists. They claim that this is a benign piece of legislation that would give individuals free choice between optometrists and ophthalmologists, as if they do not already have this choice. The bill unfortunately goes far beyond this premise and raises issues of utmost importance to the entire medical profession.

These "Freedom of Choice" bills have stated that an optometrist should be entitled to payment for optometrical service in the same manner as "practitioners of other professions." They also provided that no "board, body, agency, official, or institution, whether public or private, receiving public funds, shall interfere with any individual's right to free choice of practitioner as defined in the Optometric Code."

Hamper Administrative Personnel

It was quite clear that this bill (and this was freely admitted by optometrists in various legislative committee hearings) would prevent and hamper the administrative personnel in the Departments of Education, and Human Resources, as well as school nurses and vocational rehabilitation counselors from referring patients with ocular complaints and symptoms directly to oph-

thalmologists or even to family physicians. They have even strenuously objected to having school nurses suggest to parents of children who have failed visual screening tests that they consult their family physicians, and in essence they are asking for recognition of equality with licensed physicians who have had special graduate training in one branch of medicine (ophthalmology) and are attempting to prevent any state employee or agency from disclosing the distinction between a full medical license and a limited area licensee in advising patients to seek professional health services.

An optometrist can enter a four year school of optometry after two years of college. They are qualified by training and are licensed in Georgia only to determine the refractive error of the human eye, prescribe and dispense glasses for the correction thereof, and to prescribe orthoptic and training exercises for certain muscle imbalances. Their limited training naturally does not qualify them to diagnose the myriad pathological conditions that occur in the eye nor are they permitted by Georgia law to treat any pathological condition, to perform surgery, or to use any local or systemic drugs.

Ophthalmologists, on the other hand, must obtain their M.D. degree by attending a four year medical school. They must have a qualified internship and spend a minimum of three years in specialty training following this.

Full Examination Needed

All physicians are aware that there are literally hundreds of systemic disorders that may lead not only to blindness but also to generalized morbidity and even mortality. Many of these, such as diabetes, blood dyscrasias, brain tumors, multiple sclerosis, hyperthyroidism, hypertension, carotid artery insufficiency, and many others, will first manifest themselves by ocular signs or symptoms. These may be extremely subtle and they usually cannot be discovered without a full medical eye examination. Optometrists are not permitted by Georgia law nor are they qualified by training to use drugs, x-rays, fluorescein angiography, and the special diagnostic and surgical instruments so frequently required to make these diagnoses.

There are also numerous pathological conditions which primarily affect the eye, such as cataracts, glaucoma, tumors, retinal detachment, strabismus, primary retinal vascular disorders, uveitis, etc., that can be satisfactorily treated with prevention of blindness if the diagnosis is made in early stages. Many of these conditions do not present with loss of vision and therefore their presence cannot be detected by refraction and determination of vision but only by a complete and thorough medical eye evaluation. Early diagnosis therefore depends primarily on the patient's access to a complete medical eye examination which may require the use of cycloplegic drugs to dilate the pupil, a neuro-ophthalmological evaluation of cranial nerves II through VII, and frequently the use of ancillary services such as laboratory aids, x-ray, diagnostic drugs and biopsies. Glaucoma alone affects 2 per cent of the adult population and is as common as hypertension. It is one of the major causes of blindness in our state and can almost invariably be satisfactorily treated if the diagnosis is made in early stages. This diagnosis is not always easy and is not based on a single tonometric determination, but requires the full skill and judgement of a well trained ophthalmologist.

Increased Incidence of Blindness

Even if optometrists referred all patients whose central vision could not be corrected by lenses to ophthalmologists most cases of glaucoma and these other ocular disorders would not be picked up since central vision is not affected until later stages of the disease. Passage of a freedom of choice bill

such as H.B. 88 would have obviously seriously hampered administration of various state programs concerned with blindness and blind citizens. The Medical Association of Georgia feels that this would undoubtedly result in a great increase in the incidence of blindness and significant morbidity due to the delay in diagnosis. The increased incidence of blindness would cost the state millions in increased welfare payments and would result in the loss of millions of dollars in taxes due to loss of productivity from the citizens who have lost their vision. Several billion dollars are now being spent annually in the United States simply for welfare payments to patients already blind.

All of us must constantly remember that administrative and nursing personnel in the various state agencies have absolutely no way of determining from a patient's symptoms whether they simply have a refractive error or whether their vague symptoms may be a sign of a serious systemic illness or a serious local eye disease. The optometrists feel that they could diagnose adequately the patients and that they could be trusted to refer them to the proper medical practitioners. We absolutely refuse to accept this premise and in fact feel that the diagnosis of medical diseases is the most difficult function required of a physician and requires the highest amount of training and skill.

Admitted to Hospital Staffs

This bill would also have required various hospitals such as Talmadge Memorial Hospital, Grady Memorial Hospital, Central State Hospital, and others to admit optometrists on their staffs. In fact, according to the wording of this bill the state could probably have been enjoined from preventing the admission of optometrists and perhaps could even have been forced to start a school of optometry.

Indeed, this bill instead of being "anti-discriminatory" would have discriminated seriously against ophthalmologists.

It is time we quit running from and acting defensive around the word "discrimination." The Medical Association of Georgia insists that there is indeed a difference between physicians who have had special training and ancillary health care personnel such as technicians, podiatrists, optometrists, chiropractors, nurses, etc., and that official agencies and bodies must indeed discriminate in order to insure that our citizens obtain adequate health care.

H.B. 88 was modified slightly, but medicine's objections were not entirely removed. It was passed by the House Health and Ecology Committee and was strongly supported by Rep. Billy McKinney, Atlanta, Joe Burton, Decatur, Jesse Blackshire, Savannah, Betty Clark, Decatur, and Bill Noble, Decatur.

Fortunately this bill was defeated in the Rules Committee by a vote of 15-1 with Rep. Ward Edwards being the only person voting for the bill. This remarkable defeat was due to the hard work by Rusty Kidd and Talitha Russell, who were able to cooperate beautifully and to coordinate various witnesses objecting to this bill. Dr. Jim Kaufmann, as usual, was able to throw the entire weight of the Medical Association of Georgia against this bill.

MAG's Position

The Medical Association of Georgia's view is well summarized by a resolution of the House of Delegates which was passed unanimously in May 1967. That resolution stated in part: "Now therefore be it resolved, that the Medical Association of Georgia considers an eye examination by a licensed physician to be an integral and important part of a complete and comprehensive medical examination and that the Association does not consider an optometric examination equivalent in any way to a complete and comprehensive medical eye examination. The Medical Association of Gorgia is unalterably opposed to any legislation which seeks to have eye examination by non-medical practi-

tioners recognized as equivalent in any way to examinations made by licensed physicians."

In spite of the fact that these type of bills have been introduced over the past nine years, the members of the Legislature still are not adequately educated and informed about the difference between optometrists and opthalmologists. We are urging each member of the Medical Association of Georgia to please bring this difference up in any conversations you have with any of your representatives and to make an active effort to contact your legislators and inform them that similar legislation will probably be reintroduced in the future and to ask for their support in defeating it.

Richard K. Winston, M.D.
President, Georgia Society
of Ophthalmology
Doctors Building
Valdosta, Georgia 31603

what has the mag done for you lately?

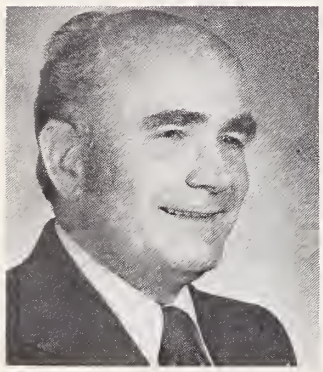
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Lastly, having been insured through St. Paul since 1956, and being in one of eight "Program" states out of the 50 states, you have the distinct advantage during the current liability insurance crisis of being able to add a partner or associate physician to your corporation or group and get him covered for professional liability insurance. St. Paul will write new business only in the "Program" states.

president's letter

Heard and Believed



THIS IS MY FIRST President's Letter. I plan to use this page during the coming year to try to convey to you, the membership of the MAG, my ideas and feelings concerning our Association. This first attempt must be of a very general nature. At Annual Session time we are reminded that the House of Delegates sets the basic policy guidelines for Council and the officers to follow. I feel I will be safe in saying that a very important policy we must adopt and follow is that of acting together. Too often each of us thinks of himself as a surgeon, internist, family practitioner, etc. We must begin to think and act as physicians first. Our front must be united. The MAG is the statewide voice of medicine. We must make it as effective as possible. There are many physicians in Georgia who belong to no society; there are others who belong to a county society but not to the MAG. We must urge each physician to support his Association with his money and his time. We must do our best to present to the public and to government the image that we are united in our efforts to provide the best health care that is possible. United in our efforts to keep costs at the lowest possible level compatable with the best care. Together we may be listened to; divided we will be destroyed one at a time.

The MAG is our voice, support it, make it heard and believed.



David A. Wells, M.D.
President, Medical Association of Georgia

Some Recent Concepts on Acute Lymphocytic Leukemia in Children

JOHN A. MANFREDI, M.D., *Decatur**

To dare to speak of the word "cure" in oncology must be done in a very careful manner. It can be safely made when referring to choriocarcinomas, Burkitt's lymphoma, and some early types of Hodgkin's disease. More recently, however, it is often being heard when referring to Acute Lymphocytic Leukemia (ALL) in children.

Much of the success in dealing with this dread disease has originated from St. Jude's Children's Hospital in Memphis, Tennessee. At their yearly symposium recently (February 28-March 1), the most recent status of their results of therapy was presented.

Since 1962, St. Jude's has been treating ALL in children according to various protocols, consisting mainly of a combination of chemotherapy, radiotherapy to the craniospinal axis, and good general patient management, both at that facility and in conjunction with referring physicians. Most recently, in what is referred to as "Total Therapy VIII," remission induction utilizes Prednisone, Vincristine and Asparaginase; preventive CNS therapy consists of 2400 Rads of cranial radiation and intrathecal Methotrexate; and continuous therapy for maintenance includes 6-MP, Methotrexate, cytosine arabinoside, and Cyclophosphamide.[1] All therapy in patients attaining remission is stopped after two to three years. As is generally true at this time in childhood ALL, over 90 per cent of the patients attain complete remission.

In the past, in children given only supportive therapy, 50 per cent died within four months after onset of symptoms (Tivey, 1952). Of St. Jude's first 41 children with previously untreated ALL, 37 attained complete remission and seven remain in continuous complete remission for 10 years, and have been off all therapy for five to seven years. This represents a 17 per cent 10-year leukemia-free survival rate. It's no wonder that the word "cure" can be heard in reference to these children, and this fine facility deserves to feel the optimism that it expresses.

One aspect of "Total Therapy" programs needs special emphasis. The most frequent cause of ending complete remission recently has been central nervous system involvement. The CNS and meninges seem to be a reservoir area for leukemic cells, and frequently in the site of relapse while the blood and bone marrow are still in apparent remission.

It has been found that radiation therapy to the craniospinal axis in insufficient doses is not effective in preventing CNS leukemia. However, patients receiving 2400 Rad cranial irradiation plus intrathecal Methotrexate had highly effective results.[2] Irradiation is now used in a prophylactic manner. In comparing results, in one survey only 2 of 45 irradiated patients had CNS leukemia terminate complete remission, whereas 33 of 49 not irradiated had CNS leukemia terminate their re-

* 2054 Lawrenceville Highway, Suite E, Decatur, Ga. 30033. Dr. Manfredi is chairman of the Leukemia-Special Cancer Committee of the DeKalb County Unit of the American Cancer Society, Georgia Division.

mission.[3] At present, cranial irradiation plus intrathecal radiation is frequently used, which causes fewer side effects and avoids the late effects of spinal irradiation.

Thus there is now clear evidence that cranial or craniospinal irradiation ± IT Methotrexate prevents relapse of ALL both in the CNS and the blood. In addition, more aggressive management of "secondary" problems in this disease have been recently shown to prolong survival and prevent morbidity in these patients. Viral infections as Varicella-Zoster are now more reasonably manageable, and the parasitic pulmonary infections with Pneumocystis carinii can now be treated successfully in some of these patients with Pentamidine.

An interesting recent discovery has been the evidence showing the relationship between severity or extent of disease in ALL and T-Cell surface markers of the lymphocytes. T-Cell lymphocytes are those presumably derived from the thymus, as contrasted with B-lymphocytes (bursa or bone-marrow-derived lymphocytes). In brief, it has been shown that there is a direct relationship between T-lymphocyte numbers and extent of disease before treatment. This may, in the future, help to provide us with newer approaches to prognostic indicators and thus to develop new treatments of childhood ALL.

A final point which needs to be emphasized is the need for cooperation of referring physicians in the overall care of children with ALL. Maintenance therapy is frequently given by referring physicians. Early diagnosis of disease, relapse, and complications is most often made by family doctors, referring physicians, and practicing oncologists. To express a personal opinion, I believe that all patients with this disease should be seen initially by a facility such as St. Jude's, both for utilization of their wealth of experience and equipment, and also so that the data may be continuously accumulated to further extend our abilities to manage this serious and potentially dread disease. ■

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Right Bundle Branch Block-Its Clinical Significance

WILLIAM C. MALOY, M.D., *Atlanta**

UNLIKE LEFT BUNDLE BRANCH BLOCK which is often but not always associated with underlying organic heart disease, right bundle branch block has been a subject of considerable controversy as to its clinical significance for a number of years. Right bundle branch block may occur as an independent electrocardiographic entity or in conjunction with other abnormalities of the conduction system such as various forms of heart block as well as anterior or posterior ramus block of the left bundle conducting system. It also has for years been considered complete or incomplete depending on the duration of the QRS complex. The most common pattern and accepted criteria for defining right bundle branch block is an RS pattern in Lead I, V-5, or V-6 and an RSR pattern in V-1 with a QRS duration longer than .12 seconds. This pattern with a QRS complex of a slightly less duration is often referred to as an incomplete right bundle branch block pattern.

The incidence of right bundle branch block varies considerably from series to series depending on the patient population and the numbers sampled. However, Johnson, et al. reported an incidence of .16 per cent in 67,375 asymptomatic subjects[1]; and the overall incidence seems to approximate 1 per cent in most hospital settings.

Categories and Clinical Significance

For the sake of review, we may divide this electrocardiographic entity into the following categories as to their clinical significance:

1. Incomplete right bundle branch block.
2. Complete right bundle branch block as an isolated electrocardiographic finding.
3. Right bundle branch block associated with left anterior or left posterior hemiblock.
4. Right bundle branch block as it occurs with acute myocardial infarction.

Incomplete right bundle branch block has long been considered by many as an interventricular conduction delay that usually progressed to complete right bundle branch block with time. However, Moore and colleagues[2] dissected the right bundle branch conduction system in dogs with an incomplete right bundle branch block pattern and found either focal or generalized hypertrophy of the right ventricle rather than any defect of the conduction system itself. In commenting on this Massing and James[3] felt that this was applicable to man and that right ventricular hypertrophy per se could contribute to the delay in right ventricular depolarization by prolonging the conduction time in the normal right bundle branch, the right ventricular subendocardial Purkinje network, or by increasing the duration of the right

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ventricular endocardial to epicardial activation time due to the increased wall thickness. Lenegre[4] found that 76 per cent of 33 patients whose right bundle branch conduction systems were examined at autopsy were normal. These patients had incomplete right bundle branch block patterns on their electrocardiograms. He also found, however, that 94 per cent of these patients had right ventricular hypertrophy. From a clinical standpoint, we often find an incomplete right bundle branch block pattern associated with patients who have underlying chronic lung disease or hemodynamic abnormalities producing an increase in right ventricular pressure or diastolic overload such as atrial septal defect.

Complete right bundle branch block as a permanent or intermittent entity is often unassociated with any underlying organic disease and, if intermittent, may be entirely rate related. Lamb, et al.[5] reported four classical cases of intermittent right bundle branch block in young otherwise healthy men which was entirely rate related. There are numerous other reports in the literature to justify this opinion. Complete right bundle branch block may, however, be associated with organic disease and when present under these circumstances is usually associated with a congenital heart disease with right ventricular hypertrophy or less likely coronary artery disease.

With Other Conduction Abnormalities

Right bundle branch block in association with other conduction abnormalities has received much attention in the past 10 years and has attained more clinical significance and understanding. Rosenbaum[6] in a critical review of this subject stated that the combination of right bundle branch block and left anterior hemiblock was a far more common occurrence than right bundle branch block associated with left posterior hemiblock. He further stated that the former was most often associated with organic heart disease due to its underlying anatomical structure and blood supply. After the bifurcation of the left and right bundle, the anterior superior branch of the left bundle courses along the anterior segment of the septum in close approximation to the right bundle and within the confines of the left ventricular outflow tract. The blood supply to this area is almost entirely dependent on the perforating branches which arise from the proximal anterior descending branch of the left coronary artery. In contrast, the posterior inferior branch of the left bundle receives a blood supply both from the anterior as well as the posterior descending branches of the coronary tree and runs in a posterior fashion away from the outflow tract of the left ventricle. It, therefore, is not subjected to the trauma and hemodynamic stress as is the left anterior division and the right bundle branch. The latter also course by and very near to the aortic valves so that the calcification and fibrotic process occurring with aortic stenosis or bacterial endocarditis affecting this valve may damage this portion of the conducting system. Therefore, the finding of right bundle branch block in association with left anterior hemiblock is generally a cause of concern when seen on an electrocardiogram and may denote underlying organic heart disease, the most common being coronary artery disease. Right bundle branch block with left posterior hemiblock is a far less common finding and may indicate a generalized sclerodegenerative process which often leads to complete AV heart block.

Right bundle branch block in the face of acute myocardial infarction is uncommon but, when it occurs, usually carries with it a grave prognostic significance. Norris and colleagues[7] reported on some 565 patients admitted to their coronary care units over a two-year period. The incidence of right bundle branch block with acute myocardial infarctions was 7 per cent, and the incidence of left bundle branch block was 4 per cent. Although the overall mortality in both instances was quite high, that with right bundle branch block was over 60 per cent. The autopsied cases were usually predictable in that the obstructive lesion in the coronary tree was a high critical anterior descending lesion proximal to the first perforating branches

of this artery which led to the ischemia and infarction of the septum in the area of the right bundle branch and anterior division of the left bundle branch. They also found that there were significantly more episodes of sudden asystole in this group with little in the way of prior warning. On autopsy the patients with left bundle branch block were found to have more diffuse disease, and the left bundle branch block had been present prior to admission in many instances. In addition, the acute infarction was less well defined at the time of autopsy.

In summary, incomplete or complete right bundle branch block as an isolated EKG finding may be of little or no clinical significance as Rotman and Triebwasser reported in an 11 year follow-up of 394 essentially asymptomatic subjects.[8] However, one should look for the possibility of underlying disease which may have caused right ventricular hypertrophy or overload. In association with left anterior or posterior hemiblock it almost always heralds underlying organic disease which may be a prelude to complete heart block or indicate the presence of coronary artery or aortic valve disease. Right bundle branch block in the presence of an acute myocardial infarction is usually an ominous sign and carries with it an overall poor prognosis because of the usual massive nature of the infarcted area and the possibility of complete heart block or asystole. ■

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IN-PATIENT PSYCHIATRIC UNIT FOR CHILDREN OPENS AT PEACHTREE-PARKWOOD

The first private, comprehensive in-patient psychiatric unit for children in the State opened February 15 at Peachtree and Parkwood Mental Health Center in Atlanta.

Out-patient services and a day-care program are part of this new service for children under 13 years of age. Initially, 10 in-patients and 10 day-patients will be accepted and all types of childhood psychiatric disorders will be diagnosed and treated. Blanca R. Anton, M.D., will head the new unit. Dr. Anton presently is acting part-time director of out-patient psychiatric services for children at Grady Memorial Hospital and is on the faculty at Emory University.

A multi-modality approach to psychiatric treatment of children is to be used. Psychiatric and social histories, physical and neurological examinations, educational evaluation and psychological testing provide basic information which will determine the treatment plan devised for each child. The following types of treatment are utilized; individual psychotherapy (play therapy); group activities and group therapy; chemotherapy; parents and family therapy and occupational, recreational, music and horticultural therapies. Special emphasis will be placed on the family therapy process. A special school will operate in conjunction with both the in-patient and day-patient programs.

Peachtree and Parkwood is a comprehensive mental health center which includes alcohol rehabilitation and drug treatment as well as psychiatric treatment for adults, children and adolescents.

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Hospital Staff Privileges for Podiatrists

J. WINSTON HUFF, *Atlanta**

A PHYSICIAN WHO SERVES on the medical staff of a hospital is sometimes required to pass upon applications for staff privileges. The recent case of *Shaw* v. *Hospital Authority of Cobb County* (507 F2d 625) decided January 29, 1975, appears to add new legal requirements which may make such decisions more difficult.

Dr. Alan Shaw, a licensed podiatrist, applied to the Hospital Authority of Cobb County for staff privileges. While Dr. Shaw's individual qualifications as a podiatrist were not challenged, the medical-dental staff bylaws and the bylaws of the Authority accorded staff privileges only to physicians and dentists. Dr. Shaw was invited to a meeting of the medical-dental staff at which, for some 30 minutes, he was allowed to pass around literature and to answer questions. His application was then denied on the basis that the bylaws did not permit staff membership for a podiatrist.

Dr. Shaw filed suit in the United States District Court in Atlanta claiming that his constitutional rights had been infringed and that the Hospital Authority had acted in an arbitrary fashion.

Primer in Constitutional Law

In order to understand the constitutional issues, perhaps we need a brief primer in constitutional law:

1. If the hospital is private, its board of directors and staff can pretty much admit or deny staff privileges as they see fit. However, if the hospital is public or has been constructed with public funds, constitutional guaranties of due process and equal protection of the law as pronounced by the courts must be observed. This does not mean that the courts will evaluate the ethical and professional competence of an applicant. It does mean that the courts will determine whether the qualifications imposed are reasonably related to the operation of the hospital and its responsibility to its patients and also whether the admission procedures are fairly administered.

2. *Procedural* due process requires that if the applicant is to be refused, he be given notice of the reasons for denial, a fair hearing and an opportunity to be heard in his own behalf.

3. *Substantive* due process requires that an applicant cannot be denied staff privileges except upon relevant, reasonable and non-arbitrary grounds.

4. Equal protection requires that all persons within a given class of persons—that is, persons similarly situated—be treated alike.

District Court Judgement

Judge Freeman of the District Court in Atlanta sustained the denial of staff privileges to Dr. Shaw. His decision pointed out that a podiatrist's practice is lim-

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

ited by law and he was not therefore licensed to handle complications which might arise; that leg and foot surgery was being adequately handled in the hospital by orthopedists whose practice was not limited; and that current surgical schedules at Cobb General were bulging. The Judge found that such factors were relevant considerations to the proper operation of the hospital. He also gave consideration to the potential liability of the hospital if a podiatrist attempted to handle an emergency.

The case was appealed to the United States Fifth Circuit Court of Appeals where Judge Freeman's decision was vacated and the hospital and its medical-dental staff were both ordered to reconsider the application. The Circuit Court decided that Dr. Shaw had not been accorded procedural due process in that he was not afforded a proper hearing. The Court stated that the term "liberty" as used in the 14th Amendment to the United States Constitution includes the right to practice the common occupations of life and to be employed by others to render the services of that occupation. A hearing before the medical-dental staff alone was not sufficient. The bylaws of the Board of the Hospital Authority and also the medical-dental staff bylaws precluded practice by podiatrists in the hospital. Therefore, said the Court, Dr. Shaw was entitled to be heard before both bodies. Further, according to the Court, these hearings should be specifically directed to this "liberty interest" which was not considered in Dr. Shaw's previous brief appearance before the staff. Finally, the Court held that physicians and podiatrists were not members of the same class and that therefore the two professions did not have to be treated exactly alike under the equal protection laws. This portion of Dr. Shaw's attack was rejected.

Concurring Opinion

A concurring opinion by Judge John R. Brown, Chief Judge of the Fifth Circuit, gives pause. He approved of the opinion and the result reached by the majority of the Court. He then added:

> "Considering all that Georgia permits and encourages them to do, the question perhaps boils down to whether any rational basis exists for denying podiatrists, or more important their patients, the essential facilities of a twentieth century hospital. Before podiatrists can be relegated in the performance of their duties to a garret, there must be a rational basis for regulations which effectively deny access to modern hospital facilities. The due process hearing, if conducted with due process, may therefore precipitate a serious question of equal protection."

This would indicate that Judge Brown may think that physicians and podiatrists indeed compose a single class of health professionals and that the equal protection argument is therefore applicable. It might also mean that in a later case Judge Brown would hold that there can be no constitutional basis whatever, perhaps other than incompetence, on which a podiatrist can be denied hospital staff privileges. ■

I've told this before . . . .

(Ed. note: The trauma in an emergency department may be more emotional than physical as author Carl Jelenko shows in this month's surprising story, appropriate in an issue devoted to emergency medicine. Other contributions to this page should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Patience, Patience, Patient

SOME YEARS AGO, in a very busy inner-city emergency department, we were having an unusually active Saturday evening. The night was cold and damp; and the waiting room was filled with a large group of patients and seekers-after-warmth. The seats were hard and pew-like. The room was dim and stuffy. All waited uncomplainingly while we managed a succession of major trauma, bleeding, myocardial infarctions, imminent abortions, and similar highly urgent problems.

After waiting perhaps two hours, one old-looking man was ushered into the first examining booth. Here he sat patiently, hands folded across his freshly pressed work trousers, tie neatly in place, until he could be seen.

The nurses, harried and worn by the extreme activity of dealing with the past group of urgent patients, hustled back and forth past him. Suddenly, one of the nurses turned on the old man. With hands on hips, feet apart, she glared at the occupant of the booth.

"You're inside, now!" she said. "Indoors, *gentlemen* remove their hats!" The old man removed his dirty brown felt fedora.

An ice pick protruded straight up from the middle of his skull!

(P.S. The old man went home two days later after the ice pick had been withdrawn most carefully by the neurosurgeon on call, as "well" as he had been on admission!)

Carl Jelenko, III, M.D.
Professor of Surgery
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Augusta, Georgia 30902

MEDICAL AUDIT TEAM SEMINAR PLANNED FOR MAY

The Medical Association of Georgia and the Georgia Hospital Association are co-sponsoring a MATS 2, one of several new programs presented by the Joint Commission on Accreditation of Hospitals. These Medical Audit Team Seminars are intended for physicians and medical record personnel who will use this experience to facilitate implementation of audit programs in their own hospitals.

The MATS 2 will present intensive training in the JCAH's Performance Evaluation Procedure for Auditing and Improving Patient Care (PEP). For physicians, there are basic and advanced sections on audit study specifications, audit criteria development, analysis and action.

The seminar will be held May 22-23 at the Royal Coach Motor Hotel in Atlanta. For additional information, contact Tom Sinclair, Georgia Hospital Association, 92 Piedmont Ave., N.E., Atlanta, Ga. 30303.

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SOCIETIES

Tom E. Nesbitt, M.D., speaker of the AMA House of Delegates addressed the **DeKalb County Medical Society** for its February 17 meeting. The March meeting's program was titled, "Hospital Director of Medical Affairs—Man or Superman" with John A. Harrel, M.D., director of medical affairs for DeKalb General speaking.

PERSONALS

Fifth District

John Atwater has been elected to the Board of Directors of the Miami, Florida based General Acceptance Corporation.

John S. Turner, Jr. and **William C. McGarity** of Atlanta are authors of articles in the February issue of the *Southern Medical Journal.*

Three Atlanta physicians served on the faculty of the fourth annual Cardiovascular Consecutive Case Study Conference April 11-12 in St. Augustine, Florida: **William H. Fleming,** assistant professor of surgery at Emory; **Spencer B. King, III,** assistant professor of medicine and radiology at Emory and director of the cardiac catheterization laboratory at Emory University Hospital; and **E. Alan Paulk, Jr.,** clinical associate professor of medicine at Emory with a private practice in consultative cardiology.

Seventh District

Jerome B. Blumenthal, Marietta cardiologist, served on the faculty of the Cardiovascular Consecutive Case Study Conference in St. Augustine, Fla. April 11-12.

Tenth District

A. Bleakley Chandler has been named chairman of the Department of Pathology for the Medical College of Georgia in Augusta. Chandler, 49, succeeds **J. Graham Smith,** chairman of the Department of Dermatology, who has been acting chairman. He has been associated with MCG since 1944 as a student or faculty member and is a diplomate of the American Board of Pathology.

New chief of the medical staff at St. Joseph Hospital in Augusta is **C. Stephen Mulherin.** Vice-president is **James L. Becton** and **R. Eugene Tanner** has been named secretary.

DEATHS

William Franklin Castellow

William Franklin Castellow, 63, director of the Sumter County Health Department died February 25 at his home in Americus.

Dr. Castellow was born in Cuthbert and had lived in Americus 39 years. His A.B. and M.D. degrees were received from Vanderbilt University. During World War II, his service brought him the Silver and Bronze Stars for heroism. He was recalled for duty during the Korean War and was a pioneer in the aerospace medical field, becoming one of the first flight surgeons in the U.S. Air Force.

Dr. Castellow retired from the Air Force as a lieutenant colonel in 1958 and was named health director of the Sumter County Health Department. He was a member of the First United Methodist Church and the Kiwanis Club. He was nominated as a Who's Who in Georgia in 1973.

Survivors include his widow, Evelyn Thompson Castellow, Americus; daughter, Mrs. Thomas Cook, Ellenwood; two sons, Bryant Thomas Castellow, II of Stone Mountain and James Thompson Castellow of Decatur; sister, brother and grandchildren.

Joel P. Smith, Sr.

Atlanta otolaryngologist Joel P. Smith, Sr., 62, died March 3. Dr. Smith was one of the founders of Doctors Memorial Hospital and served on the hospital's board of governors and board of directors. He was also a founder of the Georgia Foundation of Otolaryngology.

Dr. Smith was graduated from the Medical College of Georgia in 1947 and served his internship at Norfolk General Hospital. Residency in otolaryngology was served at Crawford W. Long Hospital.

He was a member of the Morningside Lodge No. 295 F & AM, the Atlanta Lions Club, the Atlanta Athletic Club and the Yaarab Temple.

He is survived by his widow, the former June Goforth; daughters, Mrs. Ralph A. Marks, II of Between and Miss Linda Jeanne Smith of Atlanta; sons, Joel P. Smith, Jr. and Michael G. Smith of Atlanta; sisters and brother.

J. J. Alberto Viera

Columbus orthopedic surgeon, J. J. Alberto Viera, 48, died February 11 of a heart attack.

Dr. Viera had recently been elected a fellow of the American Academy of Orthopedic Surgeons and the American College of Surgeons.

He was born in the Dominican Republic and was graduated from the University of Santo Domingo School of Medicine. His orthopedic residencies were completed in the United States.

Survivors include his widow, Mrs. Carolyn Viera of Columbus; parents, Mr. and Mrs. Manuel Viera; daughter, Miss Emma Nelly Viera; sons, Alberto, Eric and Carlos Viera; and sister.

The Month in Washington

The American Medical Association has submitted to the 94th Congress a new proposal for national health insurance (NHI).

In the parade of would-be NHI legislation before the new Congress, the medical profession's plan is the only major proposal to have been substantially revised from the offerings of previous years.

The measure is designed to provide full health care for all through private health insurance (with the exception of Medicare beneficiaries) including catastrophic illness protection.

The principal features:

- Mandated employer coverage.
- Coverage for the self-employed and unemployed with a subsidy for premium costs for those self-employed with low incomes.
- Supplemental coverage plus subsidized premium for Medicare beneficiaries in order to equalize benefits.

The major difference between the mandated plan and the Medicredit bill endorsed by the AMA in the last Congress is that the bulk of the government financing relies on general revenues rather than on tax credits, although the tax credit principle is retained for the self-employed.

Despite the 186 sponsors that backed the AMA's Medicredit plan last year—the largest body of support for any NHI measure including that of labor—considerable Congressional resistance developed to tax credits as a financing base.

Under the revised AMA proposal, most people would receive health care protection under a mandated employer program fully financed by premiums paid by employers and their employees. Participation would be optional for employees. At least 65 percent of the premium would be payable by the employer.

Jobless, Self-Employed

The former Medicredit principles would apply to insurance for the jobless and the self-employed. The individual or family would buy "qualified health care insurance," that is, insurance which meets federally established standards of benefits and policy conditions, and for those whose income falls within a defined subsidy level, the federal government would contribute towards the cost of the premium on a scale related to income.

Government contributions to premiums would be in the form of a credit against income tax or a certificate of entitlement issued by the government and acceptable by the insurer for payment of premium. An individual or family subsidy in any year would be based on its income (measured by income tax liability) for the preceding year. Limited income individuals or families having no tax liability would be entitled to a tax credit (or certificate) for the full amount of the insurance premium. For other eligible persons, the entitlement would range from 10 per cent to 99 per cent of the premium.

Non-employed Medicare beneficiaries would be eligible for federal subsidy for premiums for "qualified supplemental coverage" designed to equalize the available benefits for the elderly as for all others. Such supplemental insurance would be the same as the full insurance policy for persons under 65, but would contain a clause for exclusion of all benefits obtainable under Parts A and B of Medicare. The supplemental insurance would not cover deductibles and coinsurance under Medicare but would require no deductible or coinsurance payments for the supplemental benefits.

The plan provides for continuation of an employee's insurance following termination of employment. Such insurance would be fully paid from a special fund created from general revenues to cover periods of unemployment.

Catastrophic Coverage

The catastrophic coverage provision requires no deductible. Coinsurance would apply at a rate of 20 per cent on the cost of all covered benefits, within a ceiling limit. The poor would pay no coinsurance, and for others, the coinsurance maximum would be 10 per cent of the individual or family income, reduced by an "exclusion base." The amount of such exclusion would vary according to family size, and would be set at $4,200 for a family of four. Thus a family of four earning $15,000 would have a coinsurance limit of 10 per cent of $10,800 ($15,000 less $4,200, or $1,080). In no case, however, could coinsurance for a year exceed $1,500 for an individual or $2,000 for a family.

The ceiling on coinsurance would trigger catastrophic expense protection. All benefits under the insurance policy would thereafter continue for the remainder of the policy with no further obligation for coinsurance.

Some special provisions:

- Employers whose payroll costs are increased by more than 3 per cent as a result of purchasing mandated coverage for employees would receive a cash (or tax credit) subsidy: 80 per cent of the excess cost in the first year, continuing on a descending scale for four years following.
- Employers who failed to comply with the mandate would be liable for reimbursement to employees for expenses incurred by reason of the employer's noncompliance, and subject to a fine of up to two times what the employer would have spent in compliance.
- For the unemployed and the self-employed, the maximum premium would be 125 per cent of the average per employee premium for all large group employees in the state.
- An assigned risk pool would be established in each state. All carriers in the state would participate, and would accept risk assigned to it.
- The federal government would be prohibited from interfering with the practice of medicine.
- Physician services would be reimbursable at "usual and customary, or reasonable charges." Hospital services payments would be determined by a state agency, after consultation with providers, on a "reasonable cost basis" under acceptable methods of reimbursement including appropriate prospective rate determination systems. Other costs would be

paid on a reasonable charge or a reasonable cost basis, as appropriate.

As with the earlier Medicredit plan, the medical profession's new proposal would replace Medicaid.

NHI Passage Remote

Despite loud barks to the contrary from Democrats of both House and Senate leadership, the chances of passage of any type of national health insurance (NHI) measure this year seem remote. And the odds at this time seem to suggest that NHI may have trouble the following year. The thinking seems to be that such landmark legislation is more likely to come about in the 95th Congress due to the ever-growing restraints on the present economy.

Nonetheless, the House Ways and Means Committee's new subcommittee on Health has named an advisory panel on NHI. The list numbers more than 100 names—with more to come—and draws heavily from academia.

According to Subcommittee Chairman Dan Rostenkowski (D.—Ill.), "the advice of these experts, who will be meeting with the Subcommittee during the coming months, should be of great assistance as we try to better understand our complex health care system and how NHI can improve it."

Present plans are to study updated legislative recommendations of interested groups through April 15 and then hold few, if any, public hearings on NHI before tackling the job of framing a bill. The Subcommittee will be meeting almost every afternoon.

The advisory group was said to "contain no members who are officials of national organizations or groups that have espoused specific approaches to NHI." The members "know something that the Subcommittee should learn about and were not chosen to represent organized interests," said Rostenkowski.

Several ex-federal health officers were named, including: Wilbur Cohen, former Health, Education and Welfare Secretary; Philip Lee, M.D., and Merlin Duval, M.D., former Assistant HEW Secretaries for Health; John Veneman, once HEW Undersecretary; former Social Security Commissioner Robert Ball and a former Social Security actuary, Robert Myers.

From universities came Roberta Fenlon, M.D., of the University of California Medical School; Robert Heyssel, M.D., Director of the Johns Hopkins Hospital; Howard Hiatt, M.D., Dean, Harvard School of Public Health; Edmund Pellegrino, M.D., Professor of Medicine at Yale University; Ernest Saward, M.D., Associate Dean, University of Rochester School of Medicine; Nathan Stark, University of Pittsburgh School of Medicine; Kerr White, M.D., Johns Hopkins; and William Schwartz, M.D., chairman, Department of Medicine, Tufts University.

Economists in the health field represented included I. S. Falk, Victor Fuchs, Rashi Fein and Herman Somers.

Individual practitioners with no affiliations listed were David Williams, M.D., Laurinburg, N.C.; Darwin Richardson, M.D., Needles, Calif.; Robert Derbyshire, M.D., Santa Fe, N.M.; and Dan Billmeyer, M.D., Oregon City, Ore.

Professional Liability Insurance

The present crisis in the underwriting of professional liability insurance has become a key issue in the new Congress. The Senate Health Subcommittee has slated hearings starting in April. The House Health Subcommittee is expected to follow suit. Five major bills tackling the problem already have been introduced.

However, a ticklish jurisdictional problem has cropped up, with no one sure yet what Congressional committee should have prime legislative responsibility. Technically, it would appear that the House and Senate Judiciary committees would have a strong claim because of the legal aspects of the problem. However, the Health subcommittees as well as House Ways and Means and Senate Finance also have an obvious stake.

Principal professional liability bills already introduced include:

- H.R. 1305, By Rep. Marjorie Holt (R.—Md.), to establish a Commission on Awards.
- H.R. 1378, By Chairman Dan Rostenkowski (D.—Ill.) of the Ways and Means Health subcommittee, to provide for studies of the problem by the National Academy of Science's Institute of Medicine.
- S. 188, By Sen. Gaylord Nelson (D.—Wis.), to authorize HEW to set up a reinsurance program and to conduct studies and experiments.
- S. 482, By Senators Ted Kennedy and Daniel Inouye (D.—Hawaii), for a no-fault plan eliminating contingency fees but subjecting physicians to strict supervision.
- S. 215, By the same senators, to establish compulsory arbitration as an alternative to the above proposal.

The American Hospital Association has voted for the creation of a captive reinsurance company or comparable mechanism, to implement a national malpractice and general liability insurance program for hospitals and a "positive legislative program" to seek remedies. A one-time assessment of $4 per hospital bed would help start the plan, which wouldn't be acted upon finally until a special meeting in May.

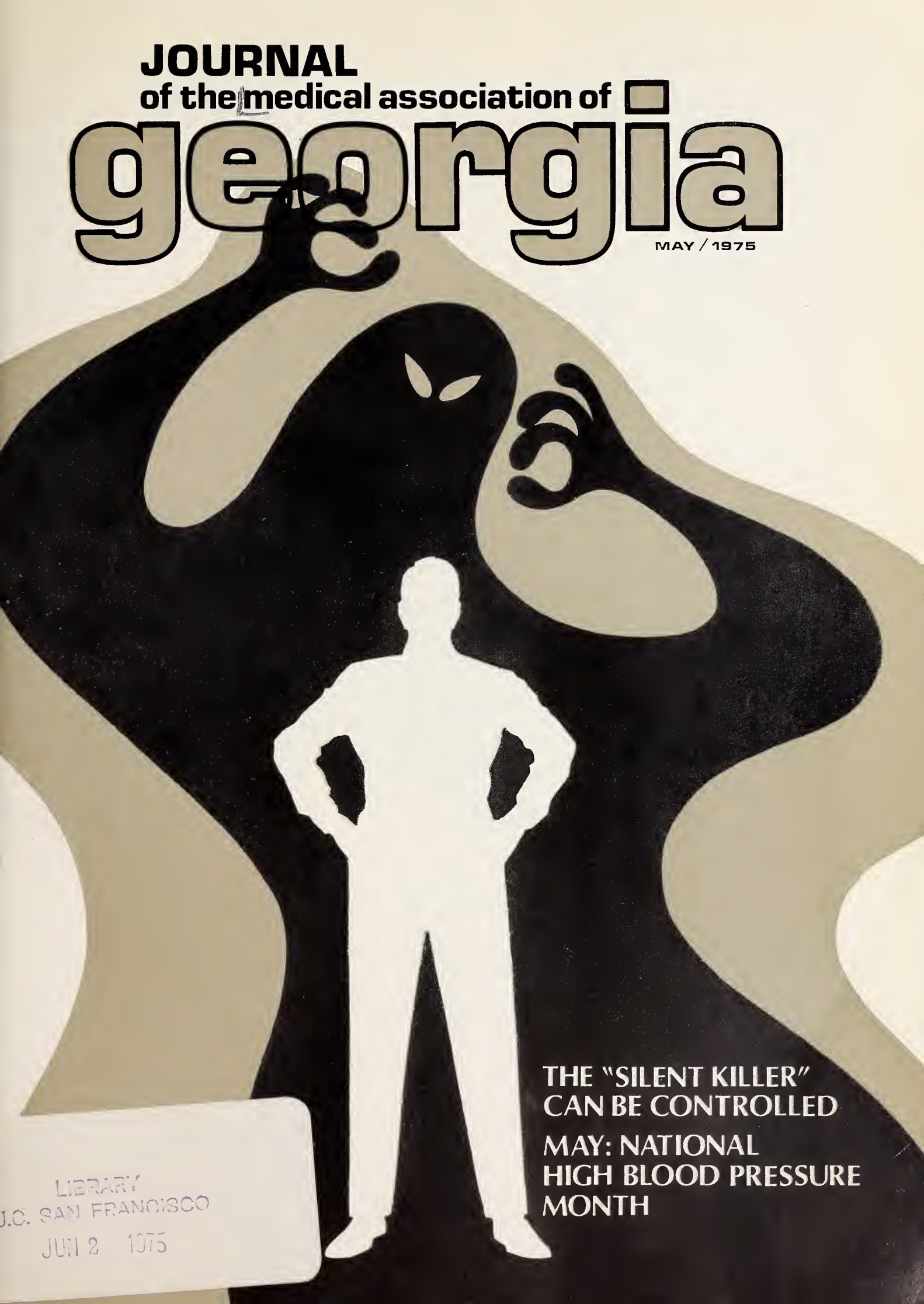
The AHA plan would provide first dollar coverage up to the limit of the policy purchased by the hospitals. It is expected that this policy would provide coverage for each and every malpractice occurrence of up to $15 million.

All employees of the hospital including house staff would be covered. Physicians under contractual compensation relationships would be included—emergency room contract physicians, anesthesiologists, radiologists, pathologists, etc., for their professional activities within the hospital.

However, AHA said the insurers have advised that private practitioners cannot be included at this time in this program.

Rep. James Hastings (R.—N.Y.), a member of the House Health Subcommittee, has announced that a national conference on medical malpractice insurance will take place in late March in Washington. The two-day conference was arranged by Hastings and the American Group Practice Association. Hastings said he believes the conference will be the first attempt "to examine the causes of the malpractice crisis and explore all alternatives so as to be able to develop a workable remedy which would protect both the doctor and his patient." ■

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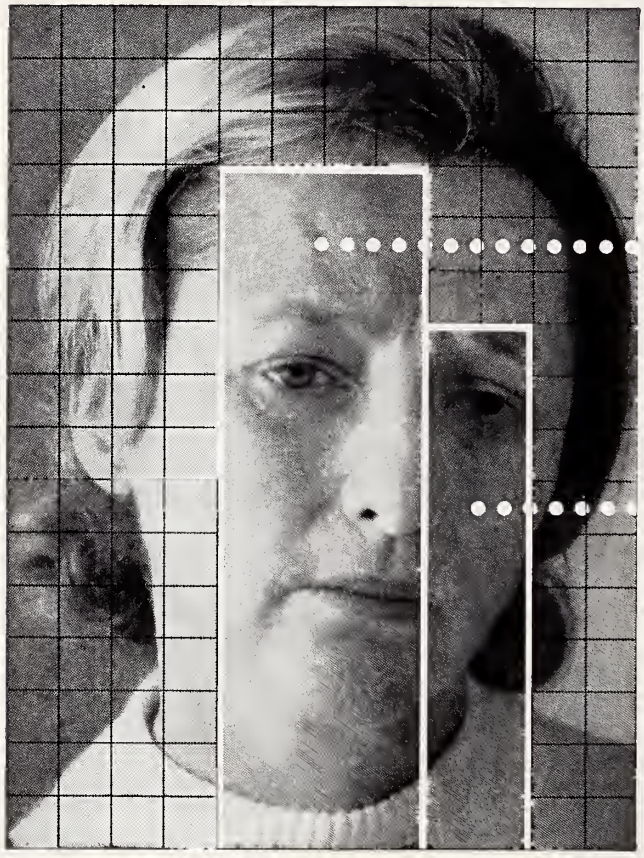


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The Ovid Bell Press, Inc.
1201-05 Bluff Street
Fulton, Missouri 65251

Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

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Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

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THE COVER

The symbolic Silent Killer, hypertension, looms large in the Georgia health care picture. An annual campaign has been launched by the Georgia Heart Association to increase awareness of the disease so that more of the estimated 800,000 Georgians affected by it will be diagnosed and brought under treatment. Information on hypertension and High Blood Pressure Month are given in a scientific article, editorial and Heart Page article this month. Cover design by Bob Hamill.

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Hypertension Care Cost

ALBERT A. CARR, M.D. *and* ANGELA C. CRANE, R.N., *Augusta**

Cost involved in the care of 240 out-patients with high blood pressure is documented.

AN ON-GOING EXPERIENCE in an out-patient hypertension care facility involving a large number of patients with high blood pressure diseases was reported in this *Journal*[1] last year. Cost was found to be an important factor. This report is follow-up information on direct cost to the patient for treatment of their high blood pressure disease.

Study Methods

The direct cost to the patient involves: 1) transportation, 2) facility fee, 3) physician fee, 4) laboratory studies and 5) medications. Transportation, based on information from the patient average cost $4.00 per visit. Cost to the patient, related to wages lost as a result of visits for care and/or for hiring a baby sitter at home, is not included. The facility fee of $7.00 per visit provides a waiting room, examining rooms with appropriate equipment and materials and secretarial assistance for appointments and charts. The physician fee is derived from the salary of the physician, nurse practitioner and physician's assistant involved, the time of their involvement (46 per cent) and the number of patient visits. This fee is $14.00 per patient visit. The cost of laboratory studies, which includes x-rays, cardiograms and biochemical tests, are actual charges made by the laboratories for the studies and represents actual cost for the patient per year. Medication cost is based on the wholesale expense to a pharmacist with 30 per cent added. The overall medication cost is based on medications actually prescribed for a period of one year, which includes: antihypertensives, potassium supplements, oral hypoglycemic agents, insulin, digitalis glycosides, Colchicine, Probenecid and Allopurinol.

Patients are divided into three groups according to the severity of their high blood pressure disease; *Severe, Moderately Severe* and *Mild*. The definitions for these groups follow.

Severe: 1) initial diastolic blood pressure 90-130 mm of Hg with any of the following—heart failure, renal failure, cerebrovascular accident, transient ischemic attack, retinal linear hemorrhages or retinal cotton wool spots (exudates); 2) initial diastolic blood pressure above 130 mm of Hg, 3) diastolic blood pressure 105 mm of Hg or greater on maximum antihypertensive medications and 4) poor pill taker.

Moderately Severe: 1) initial diastolic blood pressure 90-130 mm of Hg with either left ventricular enlargement, past myocardial infarction, angina pectoris and diastolic blood pressure controlled to less than 105 mm of Hg; 2) initial diastolic blood pressure 90-130 mm of Hg without left ventricular enlargement, past myocardial infarction, angina pectoris and diastolic blood pressure controlled to less than 105 but not less than 95 mm of Hg; and (3) initial diastolic blood pressure 90-130 mm of Hg with or without left ventricular enlargement, past myocardial infarction or angina pectoris and taking three or more antihypertensives for control of diastolic blood pressure less than 105 mm of Hg.

Mild: 1) initial diastolic blood pressure 90-130 mm of Hg with no left ventricular enlargement, heart failure, angina pectoris, past myocardial infarction, renal failure, cerebrovascular accident or transient ischemic attack; and 2) diastolic blood pressure controlled to less than 95 mm of Hg with not more than two antihypertensive medications.

* Dr. Carr is professor of medicine and chief of hypertension and clinical pharmacology for the Medical College of Georgia, Augusta, Ga. 30902. Ms. Crane is a nurse practitioner in hyptertension and clinical pharmacology at the college.

Blood pressures used for the study are sitting casual pressures. Three measurements are made and the average of the last two used for management of patient problems. Three recordings on separate days are obtained prior to therapy, whenever possible.

This report is related to 240 patients for whom cost information is available. There is now detailed information on 431 patients, many of whom have not been followed for over a one year period. There are an additional 133 patients who are relatively new to the program and are either undergoing evaluation or being initiated into the treatment program. A total of 564 patients are being followed.

Result

Since the first report[1] the patient population has grown from 307 to 564. The cost information population of 240 patients is quite similar to the overall patient population. Similarity related to severity of disease is listed in Table I. Other features of the patient population are as follow: heart failure—6 per cent, angina pectoris—7 percent, past myocardial infarction—2 per cent, left ventricular enlargement—30 per cent, cerebrovascular accident—8 per cent, renal failure—5 per cent and retinal linear hemorrhages or retinal cotton wool spots (exudates)—4 per cent.

Costs for the care of the cost information population is related to severity of the high blood pressure disease. Return visits to the physician are also directly related to severity: six visits per year for those in the *Severe* group, five visits per year for those in the *Moderately Severe* group and three visits per year for those in the *Mild* group. Overall costs are shown in Table II. Physician fees, of the total, are: 14.2 per cent *Severe;* 18.9 per cent *Moderately Severe* and 21.7 per cent *Mild*. In contrast to the relative cost for physician fees, the medication costs rise with severity of the disease: 61.6 per cent of the total for those with *Severe* disease; 44.4 per cent of the total for those with *Moderately Severe* disease and 34.1 per cent of the total for those with *Mild* disease.

TABLE I

COMPARISON—ACCORDING TO SEVERITY OF DISEASE

	Severe %	Moderately Severe %	Mild %
Cost information population— 240 patients	36.6	32.0	31.4
Detailed information population— 431 patients	31.0	28.0	41.0

TABLE II

COST INFORMATION POPULATION— COSTS PER YEAR

	Severe	Moderately Severe	Mild
Transportation	24.00	20.00	12.00
Appointment reminder	3.00	2.50	1.50
Laboratory	73.60	78.00	53.98
Medications	364.00	164.00	66.17
Physician	84.00	70.00	42.00
Facility	42.00	30.00	12.00
Total	590.60	369.50	193.65

Appointment reminders have been found to increase the percentage of patients keeping appointments as scheduled. The figure has risen from 65 per cent to 70-75 per cent since reminders have been sent. This increases efficiency of the overall operation but cost is involved, which is 50 cents per patient visit.

Diastolic blood pressure levels are related to severity of disease, before and during treatment. In general, antihypertensive medications are not given to patients in the *Mild* category, with diastolic blood pressure 90-104 mm of Hg, unless: there is either systolic hypertension, *or* there is a prominent family history of high blood pressure, *or* the patient is markedly overweight, *or* the patient is a cigarette smoker. Age, sex and race are also factors.

For those patients who are obese, weight reduction is advised. Those who smoke cigarettes are advised to stop. All are asked to limit sodium intake in their diet. The diastolic blood pressure levels are shown in Table III. During treatment, diastolic blood pressure is lower than 105 mm of Hg in 97 per cent and 90 per cent of those patients in the *Moderately Severe* and *Mild* categories and 82 per cent of those in the *Severe* category. Treatment is very successful in terms of diastolic blood pressure reduction in all disease categories.

Discussion

Expense of medications represents a major portion of the direct cost to the patient and it rises with severity of disease. Although antihypertensives are essential for effective treatment, the relative high cost and side effects are responsible for many patients refusing to continue therapy. The result is treatment failure. At least 15 per cent of the patients in this study in the *Severe* category are "poor pill takers," and "drop-outs" from continuing care represent 5-10 per cent of the overall patient population. In general, it is the patients in the *Severe* category of disease who "drop-out" from continuing care. Cost and side effects of drugs are the major

TABLE III

COST INFORMATION POPULATION—BLOOD PRESSURE CONTROL

	Severe		Moderately Severe		Mild	
% of Total	36.6%		32.0%		31.4%	
	Treatment		Treatment		Treatment	
	Before	During	Before	During	Before	During
	%	%	%	%	%	%
Diastolic blood pressure—mm of Hg						
Greater than 130	22	0	0	0	0	0
105-130	60	18	79	3	57	4
95-104	10	23	18	23	31	14
94 and Less	8	59	3	74	12	82
Mean diastolic blood pressure—mm of Hg	122	94	113	88	106	87

reasons for patients to become statistics in these two categories. Other factors such as attitudes toward sickness or health, information and understanding of the disease, medications used for treatment, convenience of care and concern of those giving the care are important. As can be seen from this report, expense of medications is considerable and can cause financial hardship for some, especially those in the low income group who are not eligible for Medicaid or other sponsored programs providing free medical care. Therefore, cost of medications should be, and is, considered in the planning of a medical regimen. For example, there are several different types of diuretics available with differences in potency, duration of action and price. The differences in price may be small, but can be of significance over a period of months and years. Local pharmaceutical practices and economics may result in differences in costs for essentially the same medications. Some antihypertensives are much more expensive than others. An example is Methyldopa which has a relatively high cost in a treatment regimen. Bulk buying by large institutions or communities could lower cost and should be considered. Although these considerations are important, the physician actually has little, if any, control over unit cost of medications. This is in marked contrast to the vast influence and control the pharmaceutical industry has on unit cost.

A drug regimen was planned and developed according to specific needs for each patient in this report. Each regimen is planned to be easy for the patient to understand and follow as prescribed, using the least amount of medication necessary to control blood pressure. Fixed dose combination drugs are used and are often effective; whereby, the same antihypertensives in individual dosage is not as effective. Such combination drugs are an effective means for making a treatment regimen less complex. This often results in reduced cost, due to more effective control of blood pressure with fewer return visits for evaluation. Side effects of the antihypertensives can increase expenses. When supplemental potassium therapy is required for potassium depletion as a result of diuretics, it can cost $85-100 per year. Reduction of elevated serum uric acid caused by diuretics, with either Probenecid or Allopurinol, can cost $31 and $77 per year, respectively. Whenever low sodium intake can be accomplished, the amount of diuretic needed, and possibly side effects, decrease. This can also reduce the amount of other antihypertensives required and result in financial savings to the patient.

Around 40 per cent of the patients in this report are overweight. Blood pressure control is easier after weight reduction and with less medication. This coincides with the experience of others.[2] Also, there is the added benefit of less chance for glucose intolerance or diabetes mellitus which require therapy.

Blood pressure is significantly higher in the patients who smoke cigarettes when compared to the non-smoker. Therefore, it is of benefit for those patients to stop cigarette smoking. This alone often makes blood pressure control easier. There is also the cost factor of the cigarettes. Two packages per day can cost around $350 per year. If a patient can afford cigarettes the money required for the cost of medications required for treating the high blood pressure disease can be obtained simply by giving up cigarette smoking.

A patient information program regarding the importance of weight reduction, low sodium diet, cessation of cigarette smoking, some knowledge of the particular high blood pressure disease involved and some knowledge of antihypertensive medications may result in better blood pressure control at reduced cost. Such a program is being investigated, directed specifically at the "poor pill taker" and will be the subject of a later report.

Appointment reminders are beneficial as a greater percentage of patients return for visits as directed. This allows for greater efficiency of personnel and can reduce overall cost.

Laboratory cost can become a problem, especially if the diagnosis of a correctable form of a high

blood pressure disease is attempted for every patient. If the guidelines specified in the previous report[1] are followed, this cost can be kept to a minimum. If the diastolic blood pressure cannot be controlled to less than 105 mm of Hg; then, a high blood pressure disease other than essential hypertension should be suspected and appropriate diagnostic studies obtained.

The patients discussed in this report were seen in a large institution where the facility fee is fixed at $7 per visit. This is a reasonable fee for the facilities and services provided. Physicians in individual or group practice may be able to provide facilities to see patients for less, depending on their circumstances.

Physician cost reported here, is the actual cost for the number of patient visits. This is also fixed as the physicians involved are geographic full-time or are paid fixed salaries. The only way physician cost could be reduced is to see more patients, which is possible with re-organization of the clinics currently in operation. The physician, nurse practitioner and physician's assistant could easily increase the patient load by 80 per cent, which would reduce the cost per patient visit from $14 to $7.85. However, the physicians do not control the personnel involved in the clinics. They are directed by institutional regulations. This makes it difficult to increase efficiency and reduce cost in the system as described. In contrast, physicians in individual or group practice have more control of their office procedures and personnel. Therefore they more than likely, can provide care at a cost less than given in this report.

A physician evaluates and has contact with all patients. However, a nurse practitioner and physician's assistant help the physician to see more patients and are of great aid in the overall patient care program. It should be emphasized that a physician still evaluates and has contact with each patient.

Emphasis should be placed on the fact that physician cost, depending on severity of disease, only accounts for 14.2 to 21.7 per cent of the total cost. Another factor of importance is that blood pressure control in the cost information group of 240 patients is excellent. The mean diastolic blood pressure is less than 95 mm of Hg for all categories of patients being treated.

Summary

This report is in regard to out-patient management and does not involve in-patient hospital costs. Every attempt is made to keep the patient out of the hospital. The treatment of high blood pressure diseases should be accomplished on an out-patient basis. In-patient costs can be extremely high and blood pressure control in the hospital does not approximate that on an out-patient basis.

Cost involved in the care of 240 patients with a high blood pressure disease is documented. It is related to varying severity of disease from *Severe* to *Mild*. Costs due to transportation, an appointment reminder, medications, laboratory studies, a physician and facility fee are all documented. Information about success of blood pressure control is given, as well as, a discussion of ways to possibly reduce cost. ■

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NEW TECHNIQUE AIDS DAMAGED KIDNEYS

A urologist-radiologist team at the San Francisco, Calif., Veterans Administration hospital has saved a veteran's kidney with the promising new technique of injecting the man's own fresh clotted blood into an artery leading to the kidney that was hemorrhaging profusely.

Tests made more than a month after show the man's kidney to be healed except for loss of somewhat extensive tissue. If Drs. Sherman Silber and Robert Clark had not tried the new technique, pioneered by urologist Silber, the man could have lost his entire kidney from massive bleeding.

Dr. Silber believes the new technique may have "great impact," as it may lead to saving of kidneys that otherwise would have to be removed surgically because physicians heretofore have been unable to stop the bleeding.

"And this is especially important," he said, "When we think in terms of kidneys; these organs are often injured, with resultant heavy bleeding, in automobile accidents or after a severe blow to the midsection or near either of the kidneys." "Also," he added, "think of what it may mean to a person with only one kidney."

X-ray studies help locate the bleeding artery or arteries, before the clotted blood is injected.

This paper attempts to correct some misconceptions regarding the future need for physician manpower.

Effects of Low Fertility Rates on Need for Physician Manpower

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In recent years, people have expressed concern about the effects of declining fertility rates on future needs for physician manpower. Some people have even suggested cutting medical school enrollments to prevent an oversupply of physicians. However, a continuation of currently low fertility rates does not necessarily mean fewer babies or fewer people in this century. This paper explores the probable effects of low fertility on population size and long-term implications for physician manpower.

Births vs. Deaths

When the so-called "baby boom" following the Second World War reached its peak in the late 1950's, the crude birth rate in the United States (24.9 per 1,000 population) reached the highest recorded level since the early 1920's. Since 1957, the crude birth rate has declined and, in 1973, reached a record low of 15.0 per 1,000 population[1] (Figure 1). Fertility rates declined to a level slightly lower than replacement reproduction, a recorded total fertility rate† of *1.9 births per woman in 1973,* compared with 2.3 in 1971 (Figure 2). A total fertility rate of 2.1 births per woman would be considered replacement reproduction, the level of fertility required for a population to replace itself given projected mortality rates and the absence of net immigration.

Replacement reproduction should not be confused with zero population growth. Although the United States has attained a level of fertility below replacement reproduction, it will probably be 60 or 70 years before there are an equal number of births and deaths and population growth ceases. In 1973, the crude death rate was 9.4 per 1,000 population as compared with the crude birth rate of 15.0 per

Fig. 1 ANNUAL CRUDE BIRTH RATES, UNITED STATES, 1960-1973

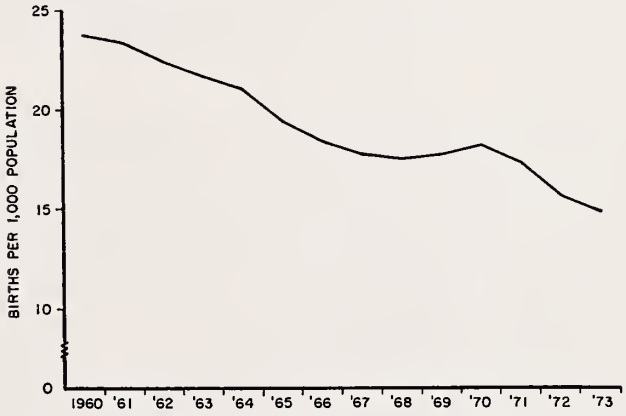
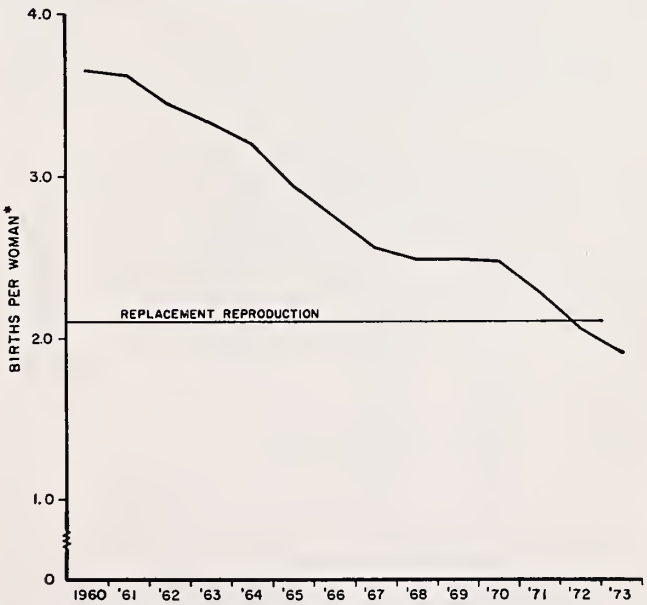


Fig. 2 ANNUAL TOTAL FERTILITY RATES* UNITED STATES, 1960-1973



*THE NUMBER OF BIRTHS THAT A WOMAN WOULD HAVE IN HER LIFETIME IF, AT EACH YEAR OF AGE, SHE EXPERIENCED THE BIRTH RATES OCCURRING IN THE SPECIFIC CALENDAR YEAR

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† The total fertility rate represents the number of births that a woman would have in her lifetime if, at each year of age, she experienced the age-specific birth rates occurring in the specific calendar year.

1,000, resulting in a natural increase (the excess of births over deaths) of 1.2 million persons in the population of the United States in that year. If fertility remains at replacement level attained in 1972, and stays constant thereafter, the total population of the United States will continue to grow, reaching a peak population of approximately 285 million inhabitants (in about 70 years, ignoring net immigration)—an increase of 39 per cent over the 1970 population.[2] After this point (around the year 2040), the population will remain constant with births equal to deaths. Both the crude birth rate and the age structure will have reached values consistent with zero population growth. Assuming replacement reproduction (total fertility rate of 2.1 births per woman) *and* continued net immigration of approximately 400,000 persons per year, it is projected that the U.S. population will reach almost 300 million inhabitants by the year 2020[3] (Table 1).

TABLE 1

SUMMARY OF QUINQUENNIAL PROJECTIONS OF THE TOTAL POPULATION OF THE UNITED STATES: 1975 TO 2020*
(Population in Thousands)

Year (July 1)	Total Population† Estimates
1970	204,879
1972	208,837
	Projections
1975	213,925
1980	224,132
1985	235,701
1990	246,639
1995	256,015
2000	264,430
2005	273,053
2010	281,968
2015	290,432
2020	297,746

*** Assumes completed cohort fertility of 2.11 average number of births per woman upon completion of childbearing.**

† Total population includes armed forces abroad.

Source of Data: U.S. Bureau of the Census: Current Population Reports, Series P-25, No. 493, Series E of Projection of the Population of the United States, by age and sex: 1972 to 2020. GPO, Washington, D.C., December 1972.

The explanation for the time lag between attaining replacement level fertility and zero population growth lies in the present age distribution of the U.S. population. Because of the "baby boom" in the late 1940's and 1950's, there is presently a disproportionate number of women of childbearing age. Therefore, as young couples replace themselves, their moderate age-specific birth rates will still yield a greater number of births than there are deaths in the total population. Projections of births are subject to changing family size values and life styles. However, we are assuming here a completed cohort fertility rate of 2.1 per woman to illustrate what would happen to the size and distribution of the U.S. population if we were to maintain replacement reproduction and eventually reach zero population growth. Although there is some disagreement among demographers about the validity of assuming continued replacement level fertility, recent survey data on birth expectations of young married women support this assumption. The average number of births expected by married women 18-24 years of age has declined from 2.6 in 1970 to 2.3 in 1973.[4] Given the even lower fertility expected for women in this age group who have not yet married, it is not unrealistic to expect women who are at present 18-24 years old to complete child-bearing with an average of 2.1 births.

Pediatric-Obstetric Populations

The effects of replacement reproduction and eventual zero population growth on the age distribution of the population is of particular interest to health planners and the medical profession.[5] The changing age distribution of the U.S. population under the assumption of continuing replacement reproduction (2.1 births per woman) is shown for the years 1985 and 2000 in Tables 2 and 3. The age structure in the year 2000 will be strongly affected by future patterns of low fertility consistent with replacement reproduction. Although only 23 per cent of the total population in the year 2000 would be 0-14 years of age as compared with 27 per cent in 1972, there will be a 5 per cent increase in the number of children in this pediatric age group. This is because the decline in the average number of births per woman will be more than offset by a 32 per cent increase in the number of females of childbearing age (15-44). There will be 29.2 and 28.5 million women in the prime childbearing ages (15-29) in the years 1985 and 2000, respectively, as compared with 26.5 million in 1972. An even greater increase in women 30 to 44 years of age is foreseen as the "baby boom" children pass through this age group. By the year 2000, there will be a 67 per cent increase in the number of females in this age group, with 25.5 and 29.8 million women in 1985 and 2000, respectively, as compared with only 17.9 million in 1972.

Thus, despite the lowest fertility rates in U.S. history, we can expect the annual number of births to increase from the lowest recorded total of 3.1 million in 1973 to a peak of 4.2 million births annually from 1983 to 1988 because of the increase in the number of women of childbearing age. Thereafter, births will decline, levelling off at about 3.9 million births per year by 2000.

TABLE 2

INCREASE IN POPULATION BY AGE GROUP AND SEX: 1972, 1985 AND 2000*
(Population in Thousands)

Age Groups	Total	Male	Female	Increase in Total Population† Number	Per Cent
	1972				
0-14	56,748	28,929	27,819		
15-29	53,366	26,886	26,480		
30-44	35,082	17,222	17,860		
45-64	42,694	20,345	22,349		
65+	20,949	8,671	12,278		
Total	208,839	102,053	106,786		
	1985				
0-14	56,360	28,787	27,573	–388	–0.7
15-29	59,225	29,977	29,248	5,859	11.0
30-44	50,788	25,261	25,527	15,706	44.8
45-64	43,403	20,504	22,899	709	1.7
65+	25,923	10,386	15,537	4,974	23.7
Total	235,699	114,915	120,784	26,860	12.9
	2000				
0-14	59,693	30,495	29,198	2,945	5.2
15-29	57,863	29,382	28,481	4,498	8.4
30-44	59,792	29,977	29,815	24,711	70.4
45-64	58,239	28,081	30,158	15,544	36.4
65+	28,841	11,503	17,338	7,892	37.7
Total	264,428	129,438	134,990	55,590	26.6

* Source of Data: U.S. Bureau of the Census: "Current Population Reports, Series P-25, No. 493, Series E of Projection of the Population of the United States, by age and sex: 1972 to 2020." GPO, Washington, D.C., December 1972.
† As compared with 1972.

Aging of the Population

One aspect of the changing age distribution which is important to health planners and the medical sciences is the aging of the population which would occur if the United States were to maintain replacement reproduction and approach zero population growth. As seen in Table 3, the median age of the population would increase from 28.1 in 1972 to 30.6 in 1985 and 34.0 in 2000. Since the hospital admission rate and hospital length of stay increase with age, this aging of the population would have significant impact on hospital services and physician manpower needs in the next 30 years. For the age group 45-64, there will be minimal growth by 1985, but, by the end of the century, there will be a 36 per cent increase and 15.5 million more Americans in this age group. The increase in senior citizens (65 years of age and over) will already be significant by 1985. Between 1972 and 1985 this group will increase by 24 per cent, or 5 million additional persons. By the year 2000, there will be 28.8 million Americans 65 years or older as compared with only 20.9 million in 1972, an increase of 7.9 million.

Given a continuation of present low fertility rates, we can expect both an increase in population size and a gradual aging of the population during the next 60 years. Both of these trends should result in increased demands for medical services.

According to 1971 National Health Interview Survey data published by the U.S. Department of Health, Education, and Welfare, the average number of reported physician visits per person per year in the U.S. was 4.9[6] (Table 4). Predictably, the mean number of physician visits increased with the age of the respondents. By multiplying the average number of physician visits per person by the 1970 population in the corresponding age groups, one may estimate the total number of physician visits which occurred in 1970. Similarly, if we assume that the age-specific physician visit rates remain constant over the next 30 years, population projections for 1985 and 2000 can be used to estimate the projected number of physician visits for these years. The estimated total visits projected for each age group

TABLE 3

PER CENT DISTRIBUTION OF THE POPULATION OF THE UNITED STATES BY AGE: 1972, 1985 AND 2000*

Age Group	1972	1985	2000
0-14	27.2	23.9	22.6
15-29	25.6	25.1	21.9
30-44	16.8	21.6	22.6
45-64	20.4	18.4	22.0
65+	10.0	11.0	10.9
Total	100.0	100.0	100.0
Median age	28.1	30.6	34.0

* Source of Data: U.S. Bureau of the Census: "Current Population Reports, Series P-25, No. 493, Series E of Projection of the Population of the United States, by age and sex: 1972 to 2020." GPO, Washington, D.C., December 1972.

TABLE 4

PROJECTED NUMBER OF PHYSICIAN VISITS, 1985 AND 2000

Age Group	Average Number of Physician Visits Per Person Per Year*	Population (in Thousands) Census 1970	Population (in Thousands) Projections 1985	Population (in Thousands) Projections 2000	Estimated and Projected Number of Physician Visits (in Thousands) 1970	Estimated and Projected Number of Physician Visits (in Thousands) 1985	Estimated and Projected Number of Physician Visits (in Thousands) 2000
0-24	4.4	93,340	94,383	99,957	410,696	415,285	439,811
25-44	4.8	47,995	71,991	77,391	230,376	345,557	371,477
45-64	5.4	41,810	43,402	58,239	225,774	234,371	314,491
65 & over	6.7	20,066	25,923	28,841	134,442	173,684	193,235
All Ages		203,211	235,699	264,428	1,001,288	1,168,897	1,319,013

* National Center for Health Statistics: Current Estimates from the National Health Interview Survey, U.S.—1971; Vital & Health Statistics Publication Series 10, Number 79, February 1973.

TABLE 5

PROJECTED NUMBER OF SHORT-STAY HOSPITAL DAYS, 1985 AND 2000

Age Group	Average No. of Hospital Days Per Person*	Population (in Thousands) Census 1970	Population (in Thousands) Projections 1985	Population (in Thousands) Projections 2000	Estimated and Projected No. of Short-stay Hospital Days (in Thousands) 1970	Estimated and Projected No. of Short-stay Hospital Days (in Thousands) 1985	Estimated and Projected No. of Short-stay Hospital Days (in Thousands) 2000
0.24	6.5	93,340	94,383	99,957	606,710	613,489	649,721
25-44	8.4	47,995	71,991	77,391	403,158	604,724	650,084
45-64	12.9	41,810	43,402	58,239	539,349	559,886	751,283
65 & over	17.5	20,066	25,923	28,841	351,155	453,653	504,718
All Ages		203,211	235,699	264,428	1,900,373	2,231,752	2,555,806

* National Center for Health Statistics: Current Estimates from the National Health Interview Survey, U.S.—1971; Vital & Health Statistics Publication Series 10, Number 79, February 1973.

are also shown in Table 4.

In 1970, there were 252,778 non-federal physicians active in direct patient care who were practicing in the United States.[7] If these physicians had a total of 1,001,228,000 patient visits, then each physician had an average of 3,961 visits per year. If this ratio were to be maintained, 295,101 physicians would have to be available in 1985 to see the projected 1,168,897,000 patient visits; a 17 per cent increase required in the number of physicians between 1970 and 1985. By 2000, approximately 333,000 physicians would be needed to take care of the projected 1,319,013,000 patient visits. The 80,222 additional physicians needed represent a 31.7 per cent increase in practicing physicians between 1970 and 2000. Whereas 5 per cent of this needed increase is due simply to the larger proportion of older persons in the population in the year 2000, it is important to note that almost half of the increase in projected number of outpatient visits will be among patients over the age of 45.

Demand for Hospital Services

The independent effect of the changing age distribution on demand for hospital services will be even greater than its effect on demand for physician outpatient services. Again, taking our baseline hospitalization rates for each age group from the 1971 National Health Interview Survey, and population projections from Table 2, we can estimate the number of days spent in short-stay hospitals in 1970, 1985, and 2000 (Table 5).* The total number of days spent in short-stay hospitals will increase from approximately 1.9 billion in 1970 to 2.6 billion in the year 2000. Of this increase, 12.6 per cent can be attributed to the independent effects of population aging.† The rest of the increase is due to simple growth in population between 1970 and 2000. However, 55 per cent of the expected increase in hospital days represents hospitalizations of persons 45 years of age or older. Both the increased number of hospital days and the increase in outpatient visits will necessitate expansion of available physician manpower during the next 60 years. However, demand for medical services will not necessarily occur evenly across all medical specialties or geographic areas. The need is likely to be greatest for family physicians, geriatric specialists, and for physicians willing to practice in rural areas.

Factors Affecting Demand

It should be noted that many of the assumptions upon which the preceding projections are based might be challenged. For example, one might ques-

* A short-stay hospital is defined as one in which the type of service provided by the hospital is general; maternity; eye, ear, nose, and throat; children's; or osteopathic; or it may be the hospital department of an institution.

† If the population of 264,428,000 in year 2000 had the same age distribution as the 1970 population, the estimated number of hospital days would be 2,472,931,000. The difference between this number and the actual projected number of days represents that part of the increase between 1970 and 2000 which is attributable to the older age distribution of the population in year 2000.

tion whether an average annual patient load of 3,831 visits per physician will or ought to continue during the next 30 years. Furthermore, it may be unrealistic to assume a continued level of consumer "demand" of approximately 4.9 physician visits per person per year. Smaller families in the future will mean a higher per capita income and, perhaps, an increase in the proportion of families who can afford the "luxury" of optional medical services such as preventive care. Similarly, the introduction of a national health insurance program could also drastically affect demand for medical services. Improved education and referral for existing public health services, better transportation facilities, and greater proximity to services afforded by increased urbanization are other factors that could affect demand significantly during the next 30 years. Inasmuch as most of these factors should operate to *increase* demand, the projected increases in physician manpower needs presented here probably should be regarded as minimum estimates. ■

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NOTE CHANGES IN CHAMPUS BENEFITS

Reminder—several important changes were initiated March 1 in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

For instance, the following are no longer CHAMPUS benefits: 1) The services of pastoral, marriage, family and child counselors even though the services are prescribed or recommended by a physician; 2) Treatment for obesity when obesity is the sole or primary condition being treated. Such treatment would be payable only when it is clearly a part of treatment for another condition that qualifies for payment; 3) Plastic reconstructive surgery that is done only to help the psychiatric or emotional needs of a patient. Plastic surgery to correct trauma, congenital defects, abnormal bodily functions or to relieve pain is still a benefit.

Another new regulation says that each admission to a hospital or other inpatient treatment facility will require a cost share by the patient. The previous practice was to treat successive admissions as one admission when not more than 30 days had elapsed between discharge and readmission. This new practice will apply even though the patient is transferred from one hospital to another or is discharged from one hospital and admitted to another on the same day. The only exception concerns maternity care.

The following pertains to allied health professionals/therapists who can furnish services to CHAMPUS beneficiaries only upon the direct referral of a doctor of medicine or osteopathy. The referring physician must prescribe, in writing, the specific services, required of the allied health professional/therapist, the estimated time such services will be necessary, and provide confirmed or provisional diagnosis. The prescribing physician must recertify the need for services by the allied health professional/therapist every 30 days. This recertification must also contain the physician's estimate of how much longer such services will be required. If the referring physician relinquishes control of the case, payment for care provided by the allied health professional/therapist will cease as of that date. This is, the patient must be under the continuing primary management of a doctor of medicine or osteopathy when receiving care from allied health professionals/therapists; otherwise their services are not considered program benefits.

All psychologists rendering services to CHAMPUS beneficiaries on a fee for service basis must possess a doctoral degree in clinical psychology and have a minimum of two years supervised experience in clinical psychology in a licensed hospital or licensed mental health center, or other appropriate clinical setting as determined by the Director, OCHAMPUS. The requirement that the individual be licensed or certified to provide services within the jurisdiction where the services are rendered remains in effect.

For additional information, contact CHAMPUS at 938 Peachtree St., N.E., Atlanta, Ga. 30309, (404) 875-9505.

A controlled study of 39 cases utilizing non-prescription, inexpensive ointments.

A New Use for an Old Ointment: Lantiseptic Ointment as a Treatment for Diaper Dermatitis

W. SCOTT JAMES, M.D., *Atlanta

PROBABLY THE MOST common form of dermatitis seen in a general pediatric practice is that found in the warm moist and dark areas of skin covered by the diaper. This condition accounts for a good number of phone calls to the physician, office visits and prescription writing. An excellent overview of diaper dermatitis by Koblenzer postulates that "there are in excess of 5,000 million diaper days annually in the United States and, thus there may well be 200 to 500 million morbidity days annually from diaper dermatitis."[1] Although this morbidity is not as serious as that associated with otitis media, tonsillitis or pulmonary diseases, it nevertheless causes quite a lot of concern to the parents and is a nuisance to the busy practitioner. There are many over the counter preparations available for diaper rash, and usually two or more have been tried before the physician sees the patient. Usually the physician then resorts to prescribing an expensive cream or ointment containing steroids and/or an antifungal agent. This study was launched in an effort to determine if an inexpensive non-prescription ointment could be more effective than one of the other more widely used ointments.

Materials and Methods

Lantiseptic Ointment (Corona) had its origin as a useful product in veterinary medicine as early as 1906. In 1936 a search was begun to find a suitable antiseptic component which would be safe to use in this ointment for treating skin irritations in humans. Only the organic mercurials showed promise when actually incorporated in the ointment, and the present formula contains 0.067 per cent parachlormercuriphenol (1:1500 concentration). Studies have shown that this small concentration is nontoxic by absorption or ingestion of the ointment, but does cause a zone of 7-8 mm of inhibition of growth of Staph Aureus on blood Agar.[2] A normal application of Lantiseptic to skin surfaces is about one tenth of one gram of ointment per four square inches. One tenth of one gram of Lantiseptic contains only 0.000046 gms of mercury (Hg); whereas, 0.1 cc of 2 per cent mercurochrome contains 0.0005 gm of mercury (10 times as much as Lantiseptic).[2] The other components of Lantiseptic Ointment are: hydrated base of lanolin and rich lanolin derivatives with petrolatum, beeswax, sodium borate and aromatic oils. White's A & D Ointment contains vitamins A and D in a petrolatum lanolin base but no antiseptic agent.

The mothers partaking in this study were asked to apply tube A (Lantiseptic) to the left buttock and perineum after each diaper change and to do likewise with tube B (A & D Ointment) to the right side. The mothers were unaware of what ointments were in the tubes, and they were to keep notes on the effects of each ointment on the rash (if any) and how quickly any changes occurred. They brought their babies back to the office in five to seven days for the physician or nurse to evaluate the degree of change in the rash. At the initial visit the rash was graded on a I-V basis. Grade I represented a one inch area around the rectum or perineum; Grade II a two inch area—and so on. The rash was checked as to whether it was oozing, macular, papular, bleeding, dry or raised. Cultures were taken for fungus and bacteria in the cases that did not have some other ointment already on the rash or where the rash was moist or inflamed.

Good Response to Lantiseptic

Cultures were taken for bacteria and fungus in 23 of the 39 cases. Of these cultures, six (26 per cent) grew out Candida Albicans. Of these six, only one

* Suite 100, Northside Medical Center, 275 Carpenter Dr., Atlanta, Ga. 30328. The Lantiseptic Ointment for this study was supplied by the Corona Manufacturing Company, P.O. Box 1214, Atlanta, Ga. 30301.

failed to respond to Lantiseptic. All six showed little or no response to the A & D Ointment. As would be expected, many different bacteria were recovered. In their order of prevalence, they were as follows: E. Coli, Enterococcus, Enterobacter, Staph Aureus, Klebsiella, Streptococcus faecalis, and pseudomonas. None of the cases showed that A & D Ointment was superior to Lantiseptic Ointment in the clearing of the diaper rash. Equal degree of improvement of the diaper rashes occurred in 5 (12.8 per cent) of the 39 cases. Both Lantiseptic and A & D Ointment showed complete improvement in 8 (20.5 per cent) of the 39 babies. Thirty-five (89.7 per cent) of the cases showed a definite degree of improvement with Lantiseptic and in 22 (56.4 per cent) of the babies Lantiseptic showed complete recovery of the dermatitis. No improvement was noted with either Lantiseptic or A & D in 3 (7.7 per cent) of the babies. In no case was there noted any irritation by Lantiseptic or A & D Ointment. The mothers compared Lantiseptic as superior (79.7 per cent), the same (16.7 per cent) and no better (3.6 per cent) to other products they had tried with the same rash.

Discussion

Excellent papers have already been published on the etiology of diaper dermatitis and the treatment with steroids, antifungal agents and buffered boric acid creams.[1, 3, 4, 5] A search of the literature failed to reveal any controlled studies dealing with the effects of any non-prescription ointments for diaper rash.

Since the steroid and antifungal agents are expensive and perhaps overused in private practice, it was hoped that a non-prescription, relatively inexpensive ointment could be used by parents with better than average success. Lantiseptic Ointment was well accepted by the mothers as a pleasantly scented, easy to apply ointment. Many of the mothers commented that they had used two or three ointments prior to entering the study, and that within 24 to 48 hours after starting the study, the Lantiseptic Ointment cleared the rash.

Conclusions

Two inexpensive non-prescription diaper rash ointments were compared in a study using 39 babies each serving as its own control. The results showed that Lantiseptic Ointment was superior to A & D Ointment in completely clearing 56.4 per cent of the cases and clearing the rashes to a greater degree in 89.7 per cent. One unexpected finding was that Lantiseptic Ointment cleared five out of six rashes where Candida Albicans was cultured. From these findings, we feel that Lantiseptic Ointment can be recommended as a superior preparation to be used in the management of uncomplicated diaper rashes.

Acknowledgements

We are grateful to Diane Kuglar, R.N. for technical assistance in this study and for the sharing of patients by Martin Moran, M.D. and Louie H. Carrington, M.D. ■

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what has the mag done for you lately?

UTILIZATION REVIEW: This past January, the MAG Council reviewed the HEW's hospital utilization review regulations requiring admission certification, concurrent review and medical audit studies. The AMA has gone to court to prevent the implementation of these regulations. While this action was being taken, the MAG, as well as other organizations communicated both with Secretary Caspar Weinberger and our congressional delegation regarding our concern with the UR regulations. Because of the variety of pressures placed upon HEW, the implementation date was postponed to July 1, 1975. It is hoped that if the courts do not rule in favor of AMA by that date, hospital medical staffs will have had sufficient time to gear up for the required review activities. Additionally, the Georgia Medical Care Foundation's CHEC program of concurrent review is expected to be operational by July 1, 1975 so that it might serve as a model for Georgia's hospitals.

Generally favorable results are reported from this four year study.

Experience With 20 Patients Treated With Lithium Carbonate

DAVE M. DAVIS, M.D., *Atlanta**

SINCE THE INTRODUCTION of lithium salts into psychiatric usage by Cade in Australia in 1949, numerous studies have demonstrated the efficacy, side effects, and practicality of the use of lithium in manic-depressive psychosis. In the United States, investigative studies were begun in the mid-1960's, and the medication was released for general usage by physicians around the end of 1969.

This study is a report of the use of lithium carbonate in 20 patients, including some who have been on the medication for up to four years. To be included in the study, patients had to be diagnosed as suffering from manic-depressive illness, either circular, manic, or depressed type. Later findings in two cases have led to a change in diagnosis to schizo-affective schizophrenia.

All patients, prior to receiving lithium, received a complete psychiatric work-up, physical examination, and social history. Laboratory studies performed were complete blood count, urinalysis, SMA 12, electro-cardiogram, chest film, and a thyroid study.

In the earlier part of the study, patients were hospitalized for initiation of lithium therapy. More recently, two patients have been started on lithium carbonate on an outpatient basis; however, these patients were selected for reliability, and lack of severe symptomatology at the time.

Rating Scale

After initial establishment on a lithium dosage which produced blood levels in the range of 0.5 mEq/l-1.5 mEq/l, patients were seen on an outpatient basis and the maintenance dosage controlled through periodic (usually monthly) blood levels. No differentiation was made between the lithium carbonate as manufactured by any of the three American pharmaceutical houses (Roerig, Rowell, or Smith Kline & French). This maintenance dosage was given in one daily dose at bedtime. Response to treatment was measured in two ways: one measure was the number of repeat hospitalizations; the second was according to a rating scale, as reported by Sikes and Sikes,[2] as follows:

> *Very good effect*—This category includes those patients who had a complete or almost complete disappearance of all psychotic symptoms and a return to full function.
>
> *Good effect*—This category includes those patients who improved sufficiently to be able to function in their duties as breadwinner or housewife and were able to expend more energy for longer periods without severe fatigue or impairment of cerebral function.
>
> *Fair effect*—This category includes those patients whose improvement was more subjective but who were able to function more adequately on a limited scale.
>
> *No effect*—These patients showed no beneficial response to lithium treatment.

Tables 1 and 2 show the frequency of re-hospitalization in males and females. In the male group (Table 1) only one patient required re-hospitalization. This patient was a 19-year-old adolescent, who while doing well, and despite continuous warning, discontinued his medication on his own. "I wanted to see if I really needed it." On the sixth day following his abrupt discontinuance of the lithium, he developed a florid manic attack and was re-hospitalized and re-established on lithium carbonate.

In the female group (Table 2) three re-hospitalizations in two patients were due to patients' discontinuing their medication on their own. In all three cases, severe manic symptoms developed within 10 days, which required re-hospitalization and re-implementation of lithium.

One of the two schizophrenic patients required three subsequent re-hospitalizations. One was for lithium intoxication, when the patient decided to double her medication on her own, without prior consultation; her reasoning was, "If three help, then six should help more!" Her two other hospitaliza-

* Director of Psychiatric Services, Peachtree and Parkwood Mental Health Center and Hospitals, 1999 Cliff Valley Way, N.E., Atlanta, Ga. 30329.

TABLE 1

RE-HOSPITALIZATIONS IN MALES BEFORE AND AFTER TREATMENTS WITH LITHIUM CARBONATE

Age	Previous Psychiatric Hospitalizations	Months on Lithium	Hospitalizations Since on Lithium	Comments
44	18	6	0	
19	1	18	1	Stopped Li on own
45	2	16	0	
58	10	49	0	
68	3	6	0	Stopped—neuro side effects
40	3	2	0	
40	2	6	0	
51	4	¼	—	AMA
61	8	6	0	
46	3	27	0	
53	1	6	0	
26	5	28	0	

TABLE 2

RE-HOSPITALIZATION IN FEMALES BEFORE AND AFTER TREATMENT WITH LITHIUM CARBONATE

Age	Previous Psychiatric Hospitalizations	Months on Lithium	Hospitalizations Since on Lithium	Comments
29	1	6	0	
46	1	1	—	Stopped with M.D. consent
67	16	1	—	Stopped—neuro side effects
57	5	9	0	
49	2	1	—	Dx changed to SAS
55	4	52	2	Twice stopped Li on own
56	6	25	1	Stopped meds on own
41	6	28	3	One readmit. for Li intox. when pt. inc. Li on own. Dx changed to SAS

tions were for depression, and severe personality disorganization, which followed a separation from her husband.

Table 3 shows the results of treatment in the overall group, according to the rating scale. Of the 20 patients studied, 12 had circular disease, three manic attacks only and three depressive attacks only. Two patients, originally diagnosed as manic-depressive, later had their diagnoses changed to schizo-affective schizophrenia, due to the appearance of gross personality fragmentation. Of the 14 manic-depressive patients who have been continued in follow-up, all have had a good or very good response.

The five patients reported who were lost to follow-up, or who are not on lithium deserve some further comment. One patient signed out of the hospital against medical advice before being stabilized on a lithium dosage. Lithium was discontinued in two patients because of neurological side effects, which in both included a disturbing tremor of the upper extremities. In one patient, the lithium was stopped after her hypomanic symptoms disappeared. In this patient a frank schizophrenic process, previously masked by the hypomania, then made itself apparent. After one month on lithium, the medication was withdrawn, and the patient was treated with Thorazine. The fifth patient stopped the lithium after discharge from the hospital, with the knowledge of her physician, due to the fact that she was strongly opposed to taking any medication whatsoever. This patient has not done particularly well, and has continued to have mood swings, particularly depressions. To this point, she has refused to return to the medication, but has not required re-hospitalization.

Side Effects

Side effects in this group are shown in Table 4. Although two patients had to discontinue the lithium because of neuromuscular side effects, only one oth-

TABLE 3

TREATMENT RESULTS BY RATING SCALES

	Number	Very Good	Good	Fair	No Response	Lost to Follow-Up or Not on Lithium
Manic-depressive, circular	12	7	3	0	0	2
Manic-depressive, manic	3	2	0	0	0	1
Manic-depressive, depressed	3	0	2	0	0	1
Schizo-affective schizophrenia	2	0	1	0	0	1

er patient in the group experienced any side effects whatsoever. This consisted of some transient nausea and grogginess which disappeared without explanation spontaneously one week after its appearance.

No suicidal attempts with the lithium carbonate have occurred in the course of the study.

Maintenance Dosages

Table 5 shows the lithium maintenance dosage per 24 hours in milligrams. For the most part patients took from 900-1200 milligrams per day and maintained their levels within the safe and therapeutic range. Two male patients maintained therapeutic levels on only 600 milligrams, and one required 1500 milligrams.

As most patients required from 900-1200 milligrams per day, it is suggested that dosage sizes other than the 300 milligram tablets presently manufactured would be helpful. Capsules or tablets in 600 and/or 900 milligram size would decrease the cost, and increase the ease of ingestion for the patient.

Summary and Conclusions

The results of the treatment of 20 patients with lithium carbonate are presented. In the manic-depressive group, no patients have been re-hospitalized, except for three patients (four hospitalizations) who discontinued their medication on their own and experienced an immediate resultant manic attack. This occurred despite constant repetition by the therapist of the need to continue on the medication and to not discontinue it without prior consultation. These transgressions all occurred in the earlier part of the study, and since that time, we have routinely included a relative in the monthly follow-up visits, and have reinforced to the relatives the need for continuance of the medication.

TABLE 4
SIDE EFFECTS

Muscle tremors	2
G.I. symptoms	2
Grogginess	1
None	17

TABLE 5
LITHIUM MAINTENANCE DOSAGE IN MILLIGRAMS PER 24 HOURS

	600	900	1200	1500	Not on Lithium
Males	2	3	4	1	2
Females	0	4	1	0	3

The rating scales would seem to indicate that the lithium carbonate is successful in improving the functioning of the manic-depressive group.

Two of the 20 patients had to be removed from the lithium treatment, because of neuro-muscular side effects. However, in the remainder of the patients, side effects were quite minimal.

Maintenance dosages were in the range from 900-1500 milligrams of lithium carbonate per day. It is suggested that larger dosage sizes, other than 300 milligram tablets, would be helpful. ■

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HIGHLIGHTS OF EXECUTIVE COMMITTEE
April 17, 1975

Professional Conduct Complaint: In Executive Session the Committee received and discussed a complaint referred to MAG from MAA regarding a member physician. The Executive Committee referred this complaint to the MAG Professional Conduct and Medical Ethics Committee.

Bicentennial Liaison: Established a committee for the bicentennial liaison and appointed W. Talbott Williams, M.D. of Smyrna as its chairman. Dr. Williams will suggest additional persons to serve with him.

New Members to Interspecialty Council: Received request from the Georgia Allergy and Immunology Society to become a member of the Interspecialty Council. The Society is to be notified that guidelines presently are being developed and that it will be informed later of the disposition of its application.

Nursing Home Accreditation: Suggested that staff work with the Nursing Home Association to develop on organization for the accreditation of nursing homes and report to the Executive Committee on their progress at a later date.

Appointments: Wesley Ball, of Savannah, to the Liaison Committee with the Georgia State Medical Association; Donald R. Rooney, Marietta, reappointed to the State Hospital Advisory Council for Construction and Licensure; Louis H. Felder and Howard Yager of Atlanta, to the Ad Hoc Committee on Laboratory Quality; Samuel Wilkins of Atlanta to the Cancer Committee; recommended to the Georgia Department of Human Resources for consideration of appointment to the Advisory Council on Clinical Laboratory, Blood Bank and Tissue Bank are L. David Stacy and William R. Murphy of Atlanta, and James L. O'Quinn of Augusta.

The Use of Home Medical Books in Ante-Bellum Georgia: A Letter by John Macpherson Berrien

Edited by **ROYCE MCCRARY, Ph.D., *Athens****

THROUGHOUT THE ANTE-BELLUM period Americans relied to a great extent on home medical books. Southern planters, with large numbers of valuable slaves on isolated plantations, found such tomes particularly useful. Indeed, on "every large plantation . . . a home medical book was . . . considered a necessity."[1]

In 1849 Dr. Tomlinson Fort, a prominent physician and politician of Milledgeville, Georgia,[2] entered the home medical book field. He authored and published *A Dissertation on the Practice of Medicine . . . adapted to the use of physicians and families,* a 740 page volume.[3] After publication Dr. Fort submitted copies of his work to friends and acquaintances, requesting frank appraisal of the book's value.

John Macpherson Berrien, the senior United States senator from Georgia, received a copy of *A Dissertation on the Practice of Medicine* from its author. He replied by the accompanying letter, which is printed below in its entirety.

Berrien possessed, as he noted, no professional knowledge of medicine. He was a lawyer and statesman rather than a physician. Yet his letter to Dr. Fort provides valuable insights into family medical care in ante-bellum Georgia. Berrien had been a planter on a large scale for 45 years.[4] During this time he utilized home medical books. Not only did he pronounce Dr. Fort's volume superior to previous works but he also named the earlier compendiums and mentioned when they came into common use in Georgia. His letter thus supplies the medical historian with data for understanding the quality of medical care in ante-bellum Georgia.

The original of the accompanying letter is in the Tomlinson Fort Papers, Special Collections Department, Robert W. Woodruff Library, Emory University. This letter, which has not been corrected in any way, is published with the permission of the Robert W. Woodruff Library.

Savannah 4th Dec
'49

Dear Sir

In consequence of my absence from this city for several months, I have not until within a few days, had an opportunity of seeing "Fort's Medical Companion."[5] I avail myself of the earliest moment, after examining it, which I have been able to command, to express to you the gratification which the publication of this work has afforded me. I have no knowledge of medicine,—never having given any attention to it, except as medical jurisprudence connects it with my own profession, and my opinion is therefore of little value, yet I venture to give it, content that the maxim Valeat valere quantum protest[6] shall be applied to it.

Having for many years past cultivated a plantation at some distance from this city, I have often sensibly felt the want of medical advice for my people,[7] when medical attention could not be procured to meet the exigency of the moment. Besides this, the ordinary diseases of our colored population yield readily to medicine if timely and discreetly administered. In my earlier day, *Buchan's family Physician*[8] was our guide on these occasions, but it was imperfectly adapted to our events, and some thirty or more years since, *Ewell's Medical Companion*[9] was substituted for it in families and on plantations. This, too, experience has ascertained to be defective in many particulars, and is destined if I mistake not, to be superceded by the work which you have just given to the public. It will certainly be so with me. The perspicuity with which you have described the

* Archivist of the Richard B. Russell Memorial Library at the University of Georgia, Athens, Ga. 30602.

symptoms of diseases, and their appropriate remedies, so commends your work to my judgment, that I shall unhesitatingly direct its use, and that you may find an abundant reward for your benevolent labours, is the sincere wish of yr. ser.

Dear sir, Yrs very Respectfully
Jno. Macpherson Berrien

Savannah
4th. Dec 49
To/Tomlinson Fort, M.D. —— ■

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3. Fort Tomlinson: *A Dissertation on the Practice of Medicine. Containing an account of the causes, symptoms, and treatment of diseases; and adapted to the use of physicians and families;* Milledgeville, *Federal Union Press,* 1849.
4. For a biography of Berrien, see McCrary, Royce C.: John Macpherson Berrien of Georgia (1781-1856): A Political Biography; unpublished Ph.D. thesis, University of Georgia, 1971.
5. "Medical Companion" is obviously a slip of Berrien's pen.
6. Valeat valere quantum protest. When it is necessary to be brave, no one knows how much bravery is necessary. That is, there is no point in Berrien belaboring the fact that he is to some extent going out on a limb in evaluating a professional work in a field in which he has no professional knowledge.
7. Slaves.
8. Buchan, William: *Domestic Medicine; or, the Family Physician . . . ;* Edinburgh, Balfour, Auld and Smellie, 1769. This was the first edition. There were many later British, French, and American editions. The first American edition was Buchan, William: *Domestic Medicine; or, the Family Physician . . . ;* Philadelphia, John Dunlap, 1772.
9. Ewell, James: *The Planter's and Mariner's Medical Companion . . . ;* Philadelphia, John Bioren, 1807. This was the first edition. There were many later editions.

ASTHMA INHALERS CAN POSE THREAT TO CHILDREN

"Hand nebulizers should not be prescribed routinely for the treatment of asthma in children and adolescents" because of research indicating they are unsafe in some cases, two pediatricians have warned in the December issue of *Pediatrics,* the scientific journal of the American Academy of Pediatrics.

Doctors C. Warren Bierman and William E. Pierson of the Department of Pediatrics at the University of Washington School of Medicine, said the dangers posed by the nebulizers involved both the drugs and the aerosol propellants used in the nebulizer mixtures.

Citing previous animal and human studies, the researchers said the propellants—fluorocarbons—could accumulate in concentrations large enough to induce severe heart irregularities. "With excessive usage, which is likely to occur in individuals with a severe attack of asthma, the concentration of fluorocarbons in the myocardium (heart muscle) could readily reach toxic levels," their report said.

The pediatricians also referred to recent research studies regarding the dangers of isoproterenol, the main drug used in nebulizers. They pointed out:

1. A 1967 study which showed that isoproterenol in large doses promoted easier breathing in areas of the lung which were already well ventilated, but also increased the blood flow to underventilated lung areas resulting in a lower level of oxygen in the blood. This lower oxygen level, they said, "superimposed on severe asthma predisposes the patient to sudden respiratory arrest, fatal cardiac arrhythmias, central nervous system depression, and/or severe metabolic acidosis."

2. A study in the same issue of *Pediatrics* which indicated that use of the drug even in recommended dosage may be dangerous in severe asthma cases. "This report casts doubt on the safety of isoproterenol when employed as directed in severe asthma," the pediatricians said.

3. A 1973 study which indicated reduced effect of isoproterenol with repeated use. The study, according to Beirman and Pierson, "found that prolonged exposure to isoproterenol even in subthreshhold doses led to a diminished response to subsequent administration of adrenergic drugs. Thus, the asthmatic patient could develop more severe asthma after prolonged use of a drug whose initial administration had relieved symptoms."

4. Other studies which indicated that some patients had an allergic reaction to isoproterenol, producing more severe breathing problems rather than relief.

The authors said an estimated 10 million nebulizers —supported by television advertisements and active promotion among physicians—were sold during 1974.

"Central to this entire issue of intense commercial promotion is the dubious safety of a pressurized unit placed in the hands of a young person who may use it as often as he feels necessary to control his asthma, in spite of the physician's directions," they said.

Because of the dangers pointed out in the previous studies, the researchers said hand nebulizers for children and adolescents "should be employed sparingly and only as a supplement to appropriate oral bronchodilator therapy."

Their other recommendations included:

1. "All hand nebulizers should be regulated by prescription. There does not appear to be a 'safe' hand nebulizer."

2. "Manufacturers should be required to redesign such units so that only one dose of medication can be administered in a safe period of time, and should eliminate the use of a fluorocarbon propellant. Such a delivery device has already been marketed and has been used for isoproterenol delivery in England."

3. "Until hand nebulizers have been redesigned, they should be administered to children only by a parent or other responsible adult who has been cautioned about the dangers of overdosage."

The recommendations of Bierman and Pierson were reviewed and approved by the Academy's Committee on Drugs.

1975 Legislative Actions

THE 1975-76 GEORGIA General Assembly, made up of 56 Senators and 180 House members, introduced over 2,300 bills and resolutions. One third of the members of the General Assembly were freshmen to the Legislature and consequently, a vast majority of these bills were not acted upon this year.

The following is a list of key bills of interest to MAG.

HOUSE BILLS

Optometric Discrimination—Freedom of Choice H.B. 88

Ward Edwards, Butler

MAG vigorously opposed H.B. 88 for reasons outlined in the *Legislative Bulletin*. This bill passed the House Health and Ecology Committee but received an unfavorable vote in the Rules Committee. H.B. 88 will be recommitted to the Health and Ecology Committee the first day of the 1976 session and the fight against this bill begins again. Hopefully, during the interim as many physicians as possible will contact the members of this committee and urge the defeat of H.B. 88.

Drug Substitution H.B. 152

Billy Randall, Macon
Defeated in Committee

This bill states that a pharmacist can substitute a less expensive generic or brand name drug for any drug prescribed by a practitioner licensed to prescribe drugs. H.B. 152 was defeated in the House Health and Ecology Committee. It is expected, however, that similar legislation will be introduced in 1976.

Psychologists Insurance H.B. 191

Joe Burton, Decatur
Passed House and Senate

This bill, as originally introduced, would require all insurance agencies to provide reimbursement to applied psychologists for services within their scope of practice. MAG is on record as opposing the original version of H.B. 191. The House Insurance Committee altered the bill to state that psychologists could be reimbursed for their services only if the patient had been referred to them by a physician.

Keogh Plan H.B. 393

Roy Lambert, Madison
Passed House and Senate

This bill would adopt the federal law increasing from $2500 to $7500 the amount of allowable deductible contribution to a Keogh Plan.

Grant Governor Authority to Reorganize Department of Human Resources H.B. 665

Roy Lambert, Macon
Passed House and Senate

This bill amends the Executive Reorganization Act of 1973 so as to authorize Governor Busbee to direct and implement such internal reorganization of the Department of Human Resources as he may find necessary to improve the management and administration of the functions assigned to the Department. Probably all physicians agree that the Department of Human Resources is in dire need of change. Hopefully, through H.B. 665, Governor Busbee will be able to change this bureaucratic organization into a working department from which all Georgians can benefit.

Maternity Care Insurance H.B. 719

Eleanor Richardson, Decatur
No Action

This bill, pending before the House Insurance Committee would require complete maternity care insurance coverage and complete maternity hospital care coverage in membership contracts of nonprofit hospital service corporations. MAG agrees in concept with H.B. 719 and hopes that in 1976 a version of this bill more acceptable to the insurance industry will pass. H.B. 719 is still a live piece of legislation which can be studied by the House Insurance Committee during the interim and acted on in 1976.

Health Care Services Regulation and Control (HMO) H.B. 757

Paul Bolster, Atlanta
No Action

This comprehensive Health Maintenance Organization bill received no action by the House Insurance Committee this year. This committee will probably study this bill over the interim and possibly take action in 1976. MAG has a number of items and ideas which we would like to see incorporated into an HMO bill if Georgia has to pass such a bill.

Optometric Inclusion Under Non-Profit Medical Service Corporations H.B. 956

John Greer, Atlanta
No Action

This bill would amend the Non-Profit Medical Service Corporation Act to include the services of optometrists and to include an optometrist on the boards of corporations such as Blue Cross, etc. This bill received no action by the House Insurance Committee but could conceivably be acted upon in 1976. MAG opposes this bill.

Choice of Doctor Under Insurance Contracts H.B. 996

Don Castleberry, Richland
Passed Committee

The committee substitute bill which passed the House Insurance Committee states that all contracts of accident and health insurance issued in this state shall offer to provide insurance coverages and benefits to cover services rendered by any person duly licensed to practice a healing art in this state for the treatment of any illness or injury within the scope of his practice which is covered by the policy. This version would not mandate any individual to purchase any specific type of coverage but would give each individual the right to buy, at a rate designated by the insurance company, any specific coverage he desired.

HOUSE RESOLUTIONS

Creation of Optometry School H.B. 96

Ward Edwards, Butler
Passed House and Senate

This resolution urges the Georgia Board of Regents to do a feasibility study on the creation of an optometry college in conjunction with the Medical College of Georgia. MAG and the Georgia Society of Ophthalmologists would not like to see an optometry college created here in Georgia. In order to help insure that the Board of Regents *not* recommend the creation of an optometry school, it is imperative that all members of the Board be contacted by as many physicians as possible urging them to recommend against the creation of an optometry school. The names and addresses of the Board of Regents are available through MAG.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

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SENATE BILLS

Drug Sampling S.B. 31

Bill Fincher, Chatsworth
Passed House and Senate

This bill requires a manufacturer's sales representative to distribute a dangerous drug as a complimentary sample *only* on the written request of a practitioner. MAG approved this bill.

Drug Labeling S.B. 32

Bill Fincher, Chatsworth
Passed House and Senate

MAG approved S.B. 32 which requires the manufacturer's name to be printed on the bottle which the physician or the pharmacist receives from the distributor.

Blood Donation—Age Requirement S.B. 76

Bob Bell, Decatur
Passed House and Senate

This bill changes the age requirement from 18 to 17 for those persons who wish to *donate* blood.

Vital Records—Pronouncing Person Dead S.B. 106

Pierre Howard, Jr., Decatur
Passed House and Senate

This bill amends Georgia's Vital Records Act to add to the section on determination of death a section stating that a person may be pronounced dead if it is determined that the person has suffered an irreversible cessation of brain function. There shall be independent confirmation of the death by another physician. Section (b) states that persons acting in good faith shall not be held liable. Section (c) states that Section (a) shall be cumulative to and shall not prohibit the use of other medically recognized criteria for determining death.

Clinical Laboratories S.B. 161

Bill Fincher, Chatsworth
Passed House and Senate

This bill would delete that portion of the Georgia Clinical Laboratory Act which exempts laboratories operated for performance of premarital serological tests for syphillis. It would also increase from two to three the number of laboratories that one licensed director can direct at any given time.

Hospital Records, Medical Review Committee Confidentiality S.B. 164

Bill Fincher, Chatsworth
Passed House and Senate

This bill provides that records and proceedings of hospital and extended care facility review committees and medical care foundations shall be confidential and that no civil liability shall arise as a result of actions performed within the scope of such committees. MAG vigorously supported S.B. 164.

Malpractice Insurance for State Employed Physicians S.B. 235

Culver Kidd, Milledgeville
Passed Senate

This bill would require the State to purchase malpractice insurance for the 226 physicians who are employed by the Department of Human Resources. The bill passed the Senate and is pending before the House Appropriations Committee, hopefully to be acted upon next year if funds are available.

Nurse Practice Act S.B. 268

Ed Garrard, Atlanta
Passed House and Senate

In the past there has been much controversy between the Georgia Nurses Association and the Medical Association of Georgia as to the wording of a mandatory Nurse Practice Act. Numerous meetings were held between the GNA and MAG over the past six months to work out the differences. S.B. 268 was not opposed by the Medical Association.

Abortions—Authorized by Husband and Wife S.B. 270

George T. Warren, II, Decatur
No Action

This bill would require reasonable efforts to get husband's consent to wife's having an abortion. This bill passed the Senate Human Resources Committee but was later sent back to committee for further study.

Malpractice—Professional Liability Insurance S.B. 370-373
Expert Testimony S.B. 370

Bill Fincher, Chatsworth

This bill would require any expert witness to be a physician engaged in similar medical practice either in Georgia or one of its adjacent states. S.B. 370 passed the Senate Human Resources Committee but was sidetracked by the nine lawyers in the Senate the day it was to be voted on and was recommitted to the Senate Judiciary Committee which is made up entirely of lawyers.

Medical Injury Compensation Commission S.B. 371

Bill Fincher, Chatsworth

This bill creates a Medical Injury Compensation Commission made up of two physicians, two attorneys, one hospital administrator and one member of the general public. The Commission shall make final and binding determination of any disputed claims for compensation. At the request of MAG S.B. 371 was held in the Senate Human Resources Committee for additional input and study over the interim. The reason for this request was S.B. 371 was poorly drafted by legislative counsel and since it was so late in the session, it was felt that this bill should be postponed until additional input could be made during the interim.

Georgia Medical Consent Law S.B. 372

Bill Fincher, Chatsworth

This bill would amend Georgia's Medical Consent Law by changing the definition of emergency. Like S.B. 370, this bill was waylaid by the nine attorneys in the Senate the day it was to be voted on. It was recommitted to the Senate Judiciary Committee.

Damages Recoverable Against a Physician S.B. 373

Bill Fincher, Chatsworth

This bill would limit the damages recoverable against a licensed physician for personal injury or death resulting from the acts of such physician after a certain date. The bill traces the torts recoverable in the Workman's Compensation Act. S.B. 373 was put in a study committee of the Human Resources Committee in the Senate at the request of MAG. This was done in order to have additional input into the redrafting of S.B. 373 so as to have the best possible bill available for action in 1976.

Additional Comments on Malpractice Legislation

If YOU are interested in helping MAG pass effective professional liability insurance legislation, then YOU and 4,000 plus other physicians like you in Georgia are going to have to contact each and every legislator in the state and express your views.

In the Senate there are nine attorneys; in the House of Representatives there are 36 attorneys. United these 45 attorneys have quite a bit of clout among their fellow legislators. We, the physicians of Georgia, have to unite in order to offset the power which these men have in the legislative process.

Membership of Important Committees

House Health & Ecology Committee

Sidney Marcus, Atlanta, Chairman
Ted Hudson, Fitzgerald
Billy McKinney, Atlanta
Wilbur Baugh, Milledgeville
Jesse Blackshear, Savannah
Joe Burton, Atlanta
Anne Calhoun, Augusta
Buddy Childers, Rome
Betty Clark, Atlanta
Walter Cox, Bainbridge
Bill Dover, Hollywood
Sonny Harris, Jesup
Charles Mann, Elberton
John Linder, Dunwoody
Bill Noble, Decatur
Billy Randall, Macon
John Russell, Winder
Bobby Parham, Milledgeville
Eleanor Richardson, Decatur
Calvin Smyre, Columbus

Senate Human Resources Committee

Bill Fincher, Chatsworth, Chairman
Perry Hudson, Hapeville
Parks Brown, Hartwell
Julian Bond, Atlanta
Haskew Brantley, Atlanta
Ebb Duncan, Carrollton
Ed Garrard, Atlanta
Bert Hamilton, Macon
Culver Kidd, Milledgeville
Jimmy Lester, Augusta
Henry McDowell, Savannah
Steve Reynolds, Lawrenceville
Virginia Shapard, Griffin

Senate Judiciary Committee

Howard Overby, Gainesville, Chairman
Pierre Howard, Decatur
Norwood Pearce, Columbus
Don Ballard, Covington
Peter Banks, Barnesville
Roy Barnes, Mableton
Robert Bell, Atlanta
John Foster, Cornelia
Eugene Holley, Augusta
Beverly Langford, Calhoun
Preston Lewis, Waynesboro
Bud Stumbaugh, Stone Mountain

Doctor-of-the-Day Program

This program continues to be MAG's best public relations endeavor. By the end of the session over 340 different people visited the Medical Aid Station. Nurses this year were provided by Crawford W. Long, Piedmont, Grady, Northside, Georgia Baptist and St. Joseph's. Space within the Medical Aid Station is very limited. However, one day over 70 people were treated. Hopefully, plans are in the making to procure a larger room, enabling the Medical Association to provide the members of the Georgia

General Assembly with additional medical aid apparatus. We appreciate the assistance of all the physicians who participated in this very successful program.

James Kaufmann, M.D., Atlanta
T. Gray Fountain, M.D., Albany
Judson Hawk, M.D., Atlanta
Duane Blair, M.D., Decatur
J. R. B. Hutchinson, M.D., Atlanta
Beverly Sanders, M.D., Macon
George Green, M.D., Sparta
Ivan Elder, M.D., Bremen
Micky O'Connell, M.D., Waycross
Bob Wight, M.D., Tifton
Robert Waller, M.D., Albany
George Patterson, M.D., Eastman
Timothy Hardin, M.D., Decatur
Edwin Flournoy, M.D., Albany
Stephen May, M.D., Kennesaw
Carl Crawford, M.D., Warner Robins
Morton Boyette, M.D., Albany
H. H. Butterworth, M.D., Decatur
Carl Gordon, M.D., Albany
Rose Ann Weaver, M.D., Atlanta
John Atha, M.D., Rockmart
R. L. Smith, M.D., Cochran
Allen Turner, M.D., Albany
Ollie McGahee, M.D., Jesup
James Baugh, M.D., Milledgeville
John C. Mitchell, M.D., Augusta
Ken Hoose, M.D., Decatur
Kathryn Hill, M.D., Greenville
Albert Davis, M.D., Atlanta
R. A. Dodelin, M.D., Columbus
Curtis Hames, M.D., Claxton
J. W. Chambers, M.D., LaGrange
Carl Hancock, M.D., Albany
Don Schmidt, M.D., Cedartown
William Morton, M.D., Cairo
Jack Menendez, M.D., Macon
James Hattaway, M.D., Albany
Olin Garrison, M.D., Cornelia
J. Rhodes Haverty, M.D., Atlanta
John Morrow, M.D., Monroe
Bill Hopkins, M.D., Atlanta

Any physician interested in serving as a doctor-of-the-day during next year's legislative session, please contact MAG.

Interim Meetings

The MAG Legislative Committee plans to have a number of committee meetings throughout the state during the interim period. The dates and places have not yet been decided, but notice will be sent to each of you advising you of the time, place and agenda. We hope as many physicians as possible can attend these meetings along with some hand-picked representatives and senators from whom we can gain new knowledge and ideas on certain legislative formats.

If you need any additional information on any of the above mentioned items, the MAG staff is at your service at 938 Peachtree St., N.E., Atlanta, GA 30309. Telephone (404) 876-7535, WATS Line (800) 282-0224. ■

MEDICAL PROGRAMS FUNDED UNDER APPROPRIATIONS BILL FOR FY 76

Kidney Program	**$ 300,000**	**Same as FY 75**
Cancer Program	**441,000**	**$21,000 more than FY 75**
Emergency Medical Services Program	**380,000**	**Zero funded for FY 75**
Postnatal Program	**150,000**	**Zero funded for FY 75**
MATPAK, Hypertension, Diabetes	**5,370,897**	**$3,000,000 over FY 75**
Board of Medical Examiners Executive Secretary and additional staff	**57,000**	**Zero funded for FY 75**
Georgia Medical Care Foundation	**885,000**	**$555,000 over FY 75 This money to be matched equally by a Federal grant.**
Mercer Medical School	**5,000,000**	**Same as FY 75 This money also to be matched equally by Federal grant.**

editorials
editorials
editorials

Education, Detection and Control of Hypertension

FOR THE SECOND YEAR, May is being observed as National High Blood Pressure Month in Georgia. The idea to single out one time of year for intensive education on the dangers of uncontrolled high blood pressure is good, but the problem is far too big for just one month or one year.

The control of hypertension in Georgia calls for a long-term commitment by many groups and individuals, medical and non-medical, who are concerned with the prevention of heart attack, stroke and kidney disease.

While hypertension cannot be considered a curable disease, it usually can be controlled. The treatment of hypertension is generally simple and effective, and may consist of medication, diet modification, weight control and exercise. In many instances, therapy may be as simple as a pill a day. For the average patient, such therapy is relatively inexpensive.

What is involved is a change in the awareness, attitudes and action of a sizeable portion of our population, and this takes time, especially where the viewpoints and health habits of a lifetime are concerned.

The Georgia Heart Association, which is coordinating the statewide educational campaign for High Blood Pressure Month, has an active, on-going program of high blood pressure education, detection and control.

Education, detection and control—the three go hand in hand as we work from day to day and year to year to identify hypertensives and encourage them to follow a prescribed course of hypertension control.

president's letter

Reflections on Annual Session



THE ANNUAL SESSION HAS just ended. I am not sure exactly what was decided; it takes time to review all the reference committee reports and actions taken by the House of Delegates.

One notable thing that happened was the passage of the report to implement PSRO. It was designated that the application for PSRO be made not sooner than 15 days before the deadline for physicians to receive preferential treatment. This compromise was proposed by a staunch opponent of PSRO. He is to be commended. He could have led a floor fight which might have left the MAG badly divided. I feel, instead, that we are more united now than in a long time.

Our Association is strong. Let's keep it that way by working together.



David A. Wells, M.D.
President, Medical Association of Georgia

heart page
heart page
heart page

Hypertension, the "Silent Killer," Can Be Stopped

ELBERT P. TUTTLE, JR., M.D., *Atlanta**

HYPERTENSION, AS A MEDICAL CONDITION, occupies a unique position. It is a risk factor for a number of devastating diseases long before it reaches the level of "dis-ease" status in its own right. We have recognized the importance of *advanced* hypertensive disease and dealt with it respectfully for a number of years.

Only recently have we appreciated the benefits in life expectancy with reduced morbidity that results from aggressive treatment of early and asymptomatic hypertension. No other disease offers a greater opportunity in health care. The widespread prevalence of the disease, the availability of effective drugs, and the proven benefits of treatment make it imperative that all physicians accept the responsibility for treating hypertension.

Basic Diagnostic Work-up

The basic diagnostic work-up of hypertension is well within the range of the expertise of any practicing physician. The questions to be answered are: 1) what is the level of blood pressure; 2) are there any of the simple clues that the hypertension is secondary to some other abnormality; 3) is there any evidence of target organ damage; 4) are there any contraindications to specific therapeutic drugs or complications of therapy to be looked for; 5) is there evidence of other types of organ disease which might influence the course of hypertension or response to therapy?

The blood pressure should be recorded on several occasions prior to initiation of treatment unless it is over 200/ or /125 and there is evidence of target organ damage to the heart, brain, eyes, or kidneys. During this time an initial work-up should include a modest amount of historical, physical, and laboratory data. Family history and date of onset of hypertension should be established. Cause or effects or therapeutic precautions will be suggested by history of diet, weight change, episodes of sweating, weakness, palpitations or anxiety, history of renal disease, kidney stones, renal injury, refractory anemia, history of drugs, including amphetamines, bronchodilators, monoamino oxidase inhibitors, vitamin D, calcium or antiovulatory pills as well as antihypertensive medications. Target organ damage will be suggested by history of heart failure, angina, myocardial infarction, cardiac arrhythmia or of stroke, proteinuria or loss of vision. Co-existent disease and contraindications to certain types of therapy would be suggested in diabetes, gout, peptic ulcer, mental depression, or drug allergy.

The basic physical examination should include measurement of the blood pressure at least once in both arms and a leg, and in standing and supine positions.

* Professor of medicine and co-director of the Division of Nephrology and Inorganic Metabolism for Emory University School of Medicine, 69 Butler St., S.E., Atlanta, Ga. 30303. Dr. Tuttle is a member of the Hypertension Task Force of the Georgia Heart Association. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

Ocular fundi, carotid arteries, heart, lungs, and peripheral vessels should be examined, and bruits over neck, abdomen and back are especially noteworthy. Nervousness, sweating, dilated pupils, and hyperactivity suggest thyroid or sympathetic overactivity. Abdominal palpation for enlarged or tender kidneys, a search for neurological defects and body weight can be completed in a 10-minute examination.

Laboratory data should include, at the minimum, a hematocrit and a urinalysis, but in any but the most limited care, a baseline EKG, chest film and abdominal flat plate should be obtained. The laboratory baseline profile should include blood urea or creatinine, glucose, uric acid, electrolytes and calcium.

Convincing the Patient

If the tests above can be accepted as a basal work-up for hypertension, then therapy should be begun unless clues to a correctable cause of hypertension are found therein. First in priority is to convince the patient that attention to his blood pressure, probably for the rest of his life, will pay handsome health dividends. The patient should be aware, for example, that like knowing how much one weighs, knowing one's blood pressure is an aid to controlling it, since good medicines are available. Weight loss and restriction of sodium intake are conceptually the simplest and most desirable of therapies, but practically difficult to achieve. Full daily dose of a standard long acting diuretic is the cornerstone of almost any hypertensive regimen. On top of that is added for patients in the 105 to 140 diastolic range an anti-sympathetic drug, e.g. reserpine (0.25 mg./ day maximum), methyldopa (3 gm./day maximum), or propranolol (0/040 gm. qid maximum). If this does not suffice then a primary vasodilator such as hydralazine (0/300 gm./day maximum) should be added to that. If this fails, it is most often due to kidney disease or high sodium intake. For these the use of furosemide or ethacrynic acid in addition to the thiazide will often be affective.

A key to successful blood pressure management is the concept of a goal blood pressure for each patient. If the physician and the patient strive for that goal, both will win. It's like "Motherhood": who can be against it? ■

HIGHLIGHTS OF COUNCIL
April 17, 1975

Georgia Medical Care Foundation Scope of Activities: There was considerable discussion concerning the activities of GMCF and appropriate activities in which it should become involved. Concern was expressed that GMCF, unless its management is integrated with MAG, could "slip away" as Blue Shield has done over the years. There were several recommendations made on how to solve the problem. In final action the Council approved the recommendations of the MAG Committee on Organization and Functions with some amendment.

Report of the Treasurer: Approved funds for a member of the Ad Hoc Committee to Study Physicians' Assistants to attend the Third Annual Conference on Health Practitioners in St. Louis April 7-8, 1975. Approved funds for purchasing new filing equipment for CHAMPUS, as recommended by the government management auditors. Approved the request of the chairman of the Committee on Emergency Medical Services to attend a national conference on Medico-Legal Implications of Emergency Medical Care, in Washington, D.C., June 8-10, 1975. Disapproved an appropriation to support the DeKalb County Medical Society Tel-Med program.

Membership Opinion Poll on PSRO: It was reported that MAG membership responded to the question, "Should MAG (or its subsidiary) apply for designation as agent for implementing and operation of PSRO in Georgia?" as follows: Yes—1,777; No—417; Undecided—160.

New County Society: Approved the constitution and bylaws of a new county medical society to be known as St. Johns Parish Medical Society.

Establishment of MAG Professional Liability Insurance Program: Received for information a report from a representative of an international insurance broker concerning the feasibility of establishing a captive insurance company to handle the professional liability insurance for the physicians in Georgia. The broker suggested that a feasibility study be done at a cost of approximately $15,000 plus legal fees before any final decision be made.

Health Service Areas Advisory Council: It was generally agreed that HSA's should be kept as small as possible, and Council approved a seven-area designation for the state.

Medical School at Mercer University: Adopted a resolution supporting and endorsing the establishment of a medical school at Mercer University in Macon.

Date and Site of Next Meeting: 2 p.m., Saturday, June 7, 1975 at the Pacemaker Inn in LaGrange and at 9 a.m., Sunday, June 8.

legal page
legal page
legal page

Physicians' Liability for Negligence of Hospital Staff

ERIC CARLTON, *Atlanta**

In a recent case, the Georgia Court of Appeals has considered the scope of the attending physician's liability for negligent performance of hospital employees acting at his direction.

In *Su v. Perkins,* 133 Ga.App. 474 (1974), the plaintiff patient and her husband sued her physician and the hospital to which she was admitted for the allegedly negligent injection of the drug vistaril by a licensed practical nurse employed by the hospital. The nurse apparently injected the drug, which is properly administered intramuscularly, into the patient's buttocks at an insufficient depth to reach muscular tissue. The plaintiff experienced intense pain and devitalization of subcutaneous tissue, necessitating ultimately an operation to remove damaged tissue. The testimony of an expert witness, as well as that of the defendant physician, was that due to the obesity of the patient, a longer needle should have been used to penetrate through the plaintiff's subcutaneous tissue and into her muscle. The defendant doctor had prescribed the injection of the drug, but had given no instructions as to special procedures to be followed or precautions to be taken.

The case in the Court of Appeals concerned the appeal by the physician of the denial of his motion for a summary judgment in the trial court that he would not be liable even if the nurse had been negligent. Since the facts surrounding the injection were relatively clear, the court was presented with an opportunity to consider the general issue of the liability of an attending physician for negligent supervision of hospital employees.

Exercise of Medical Skills

Under the court's analysis, the question of the physician's liability was dependent upon the character of the nurse's activity. The court contrasted activities which, though part of the physician's prescribed treatment, constitute administrative or clerical duties which do not require "either the application or the understanding of the specialized technique possessed by a skilled physician or surgeon" with activities which require the exercise of medical skill or judgment. The court stated that with respect to administrative or clerical duties, a physician should be able to rely upon the expertise of the hospital staff, and that he consequently has no duty either to give detailed instructions or to anticipate and attempt to prevent the negligence of hospital employees in carrying out his directions. When, on the other hand, a physician directs a hospital employee to exercise medical skill or judgment, he may

* Prepared at the request of the Medical Association of Georgia. Mr. Carlton is an associate with the firm of Powell, Goldstein, Frazer and Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

be liable for negligent performance by the employee if he fails to give adequate instruction.

Based upon undisputed expert testimony that the injection of drugs such as vistaril was customarily and routinely delegated to licensed practical nurses without special instruction, the court concluded that the nurse's activity was of the administrative and clerical nature for which the hospital, and not the physician, may be liable. Thus, the court deferred to recognized medical practice in categorizing the nurse's activity as one for which the physician would not be liable.

The *Su v. Perkins* case thus carries out and further defines the distinction in the Georgia case law between administrative duties, which it is reasonable and permissible for the physician to entrust to nurses and other hospital employees, and more discretionary functions and difficult procedures, over which the physician retains a duty of supervision.

BUREAUCRACY AT THE BEDSIDE
James J. Kilpatrick

(Ed. note: W. Lanier Nicholson, M.D. of Hiawassee has suggested that the Journal *reprint the Kilpatrick column below noting that it "perfectly depicts our situation here in Hiawassee and other small hospitals throughout the state." He adds, "I personally feel that an effort to get Georgia physicians to write their congressmen and senators may help. I have done so and they indicate a sympathetic ear." Reprinted with permission from the author.)*

WASHINGTON—The story comes to me from a group of country doctors out in northwest Oklahoma, on beyond Enid, but it could come from anywhere. The story provides one more example of bureaucracy gone berserk. The doctors fear their small rural hospitals are doomed.

To understand their apprehension, you have to know something of how medicine is practiced in the boondocks. In a typical community, the people at heavy sacrifice build their own small hospital. The existence of the hospital permits them to attract a handful of doctors who love country practice and accept the rural way of life. The facilities are something less than you'd find at Walter Reed in Washington, but they suffice.

These are small institutions. In northwest Oklahoma, they range from 20 beds at Waynoka to 68 at Woodward. To speak of their "staff" is to be put a large image to a small use: The 34-bed hospital at Laverne has one doctor; Cherokee, Buffalo, and Mooreland have two. The ten hospitals, with 26 doctors among them, could use 20 doctors more, but country doctors are increasingly hard to come by.

New regulations imposed by the Department of Health, Education and Welfare, having to do with Medicare and Medicaid patients, have made a bad situation worse. These regulations, demanding that every hospital adopt a Utilization Review Plan, became effective February 1. *(Since revised to July 1, 1975, Ed.)* Dr. B. D. Dotter, at Okeene, says flatly that it is "impossible" for small rural hospitals to comply.

In fairness to the people at HEW and Social Security, it should be said that they did not set out to harass or to destroy the rural institutions. Their dual purpose was to improve the quality of hospital care and to deter abuses of the system. In recent years some doctors and some hospitals have been ripping off the taxpapers by padding their bills or needlessly prolonging the hospitalization of Medicare-Medicaid patients. The formidable new regulations were thus well-intended, and they may work in institutions of 500 beds with a staff of 100. For a hospital in Watonga, Fairview or Alva, they are woefully unrealistic.

Under the new rules, the admission of a Medicare patient sets off a bureaucratic convulsion. Within two working days, the admission must be reviewed and justified by "a staff committee of the hospital composed of two or more physicians." The committee must be "broadly representative of the medical staff." No doctor may serve on a review committee if he has a financial interest in any hospital, or if he has been "professionally involved in the care of the patient whose case is being reviewed."

Out in Okeene, Okla., this is fantasy stuff. In the small hospitals of rural America, almost every staff doctor has a financial "interest" in his local hospital. Typically, in a three-doctor institution, one doctor operates, a second doctor assists, the third handles anesthesia. They are all "professionally involved" with the patients, checking at night or on weekends, giving advice, sharing the load.

In such small hospitals, staff members are thus disqualified from review. No other physicians are available. The government says flatly that it will not pay the hospital bills of Medicare-Medicaid patients whose admissions are not reviewed. And the government demands elaborate records.

At the Okeene hospital, compliance will require additional clerical help costing $1,500 a month. Every admission must be justified with a written "physician's plan of treatment, recent test findings, other supporting material, recent case history, schedule of tests planned." If a diagnosis or proposed treatment is at all unusual, "closer professional scrutiny" is required.

What is the country doctor to do? Payments under Medicare and Medicaid have become almost indispensable to a hospital's survival. The busy doctor cannot cope with the paperwork without neglecting his patients; he cannot ignore the paperwork without losing the payments. This is bureaucracy at the bedside; and out in the boondocks, nobody gains. © 1975 The Washington Star Syndicate, Inc.

I've told this before . . . .

(Ed. note: Wars and rumors of wars make for interesting stories, as our new contributor to this feature page, F. G. Eldridge, M.D. of Valdosta, shows. Correspondence concerning this page should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Outranked, Not Outwitted

DURING WORLD WAR II, Camp Blanding, Florida was utilized as a training center for National Guard units during mobilization. The National Guard units consisted for the most part of small groups of men holding key positions. When brought to full strength, a lieutenant was elevated to higher ranks over a short period of time; for instance, in one unit a chaplain who held the rank of 1st lieutenant was promoted to lieutenant colonel in a matter of a few months.

This young chaplain was a very recent graduate of his seminary and had joined a National Guard unit in 1939. In the summer of 1940 mobilization commenced. Assigned to his department was a young man, an excellent organist and pianist. Everything progressed nicely during training, but when rumors indicated shipping out to combat areas, this young fellow developed various mental aberrations and was admitted to the hospital psychiatric section.

When the alert notice was issued for the division to ship out to a combat area. it was customary for a request of release to be issued of all personnel physically able to be released and returned to their assigned units.

The chaplain's assistant was not released and the chaplain charged into the office of the psychiatrist demanding immediate release of his man.

The psychiatrist, a veteran in his field but with the rank of major, stated to the young, but ranking, chaplain, "I'm sorry, sir, but I do not think it advisable to release your sergeant because he is not suitable material for combat duty assignment." The chaplain then demanded, "I want one good reason for your opinion."

"For one thing, your sergeant thinks he is Jesus Christ," replied the psychiatrist.

"Well he just might be," retorted the chaplain. "You must know our Lord Jesus Christ was denied his true identity while He was on earth."

The psychiatrist replied, "Sir, there are three men back there who claim to be Jesus Christ and if you will select the real one, I'll release him, but I'll damn well keep the other two!"

F. G. Eldridge, M.D.
Radiological Associates of Valdosta
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the association
the association
the association

NEW MEMBERS

Ahn, Young W., MAA—A—ObG
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Cebula, Jerome M., Newton-Rockdale—Act—Path
4171 Tate, Covington 30209

Chen, Er-Wei, SW Ga.—Act—FP
Doctor's Medical Center, Edison 31746

Codington, Arthur B., DeKalb—Act—I
2644 Candler Parkway, Decatur 30032

Council, Benjamin P., Whitfield-Murray—Act—Oto
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Deriso, H. Clark, Ga. Med. Soc.—Act—Oto
44 Medical Arts Center, Savannah 31405

Friedrich, Eric W., Glynn—Act—Oto
2705 Wildwood Dr., Brunswick 31520

Galen, Wesley K., Muscogee—Act—D
3816 Caspian Dr., Columbus 31901

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Howington, Jerry W., Richmond—Act—R
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Tan, Ho T., Sumter—Act—Anes
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Veverka, Frank, Stephens—Act—FP
800 E. Doyle St., Toccoa 30577

Wirth, Fremont P., Ga. Med. Soc.—Act—N
22 Medical Arts Center, Savannah 31405

SOCIETIES

Dr. John E. Lee of Atlanta was guest speaker at the April meeting of the **Bibb County Medical Society,** explaining the use of the EMI scanner in transaxial tomography, a new tool for the diagnosis of intracranial lesions.

The **DeKalb County Medical Society,** meeting April 21, heard a program on the prospects for the Atlanta Falcons in 1975, given by Eddie Khayat, assistant coach for the team.

Georgia Medical Society members met April 8 to hear Albert C. Stolper, project manager for the AMA Criteria Development Project speak on "Model Screening Criteria to Assist Professional Standards Review Organizations: Their Development and Application."

The question of how the changing economy and the energy crises could affect the practice of medicine was examined by Andrew Young, 5th District Congressman at the April 8 dinner meeting of the **Medical Association of Atlanta.**

PERSONALS

First District

Several Savannah members have been certified as Diplomates of the following specialties: **Robert J. DeBenedetto**—Diplomate of the Subspecialty Board of Pulmonary Diseases, American Board of Internal Medicine (ABIM); **Paul F. Jurgensen**—of the Subspecialty Board of Infectious Diseases, ABIM; **Keith A. Dimond**—American Board of Nephrology, ABIM; and **Mason G. Robertson**—Subspecialty Board of Hematology, ABIM.

John H. West, Savannah, became a Fellow of the American College of Physicians at the April 7-10 annual meeting of the association in San Francisco.

Fourth District

R. Beauvais Randall, Jr., clinical assistant professor of medicine (cardiology) at Emory University, was a member of the guest faculty for the Georgia Heart Association's annual Two Days of Cardiology in Atlanta May 1-2.

Fifth District

Four Atlanta physicians were named Fellows of the American College of Physicians during the Annual meeting of the Association in San Francisco April 7-10: **Nathan H. Carliner, Ralph A. Murphy, Jr., Carter Smith, Jr.** and **William H. Whaley. Nicholas E. Davies** was named American College of Physicians Governor-Elect for Georgia to succeed **Edwin C. Evans,** Atlanta as Governor in April 1976.



MAA Auxiliary President Mrs. John K. Davidson, III and Doctor's Day founder Mrs. Charles B. Almond accept the official proclamation just signed by Gov. George Busbee.

DAY OF THE RED CARNATION

The annual observance of Doctor's Day March 31 was proclaimed officially by Governor George Busbee in ceremonies with Mrs. John K. Davidson, III, MAA Auxiliary president, and Mrs. Charles B. Almond of Winder who initiated the celebration in Bartow County in 1933 and has seen the day achieve national recognition.

Around the state the traditional red carnation found its way to lapels and hospital meal trays on the anniversary day of the first use of sulphuric ether as an anesthetic during surgery. This medical milestone was performed by Crawford W. Long, M.D. in 1842.

In Athens the St. Mary's Hospital auxiliary celebrated Doctor's Day by giving a carnation and ticket for a free cup of coffee and doughnuts to each doctor. In addition, a gift of $25 was presented to the hospital medical library.

A morning reception was held for physicians in Brunswick's hospital and auxiliary members placed leaflets on meal trays explaining the origin of Doctor's Day. The auxiliary members also held a dinner for their husbands, donated funds to the Brunswick Junior College library for the purchase of reference materials in medicine and to the AMA Education and Research Foundation.

Doctors were treated by the Clayton-Fayette County Auxiliary with carnations, coffee and doughnuts and a banquet in April as part of the observance.

The Auxiliary to the Sumter County Medical Society sponsored a dinner party to celebrate their husbands' work. Ware County's 45 physicians were honored Easter Sunday by the Woman's Auxiliary and in the following week received red carnations.

Included in the faculty of the Georgia Heart Association's annual Two Days of Cardiology May 1-2, was **Nanette K. Wenger,** professor of medicine (cardiology) at Emory.

James F. Schwartz, Atlanta, is the new president-elect of the Child Neurology Society.

Ninth District

Floyd James of Gainesville is a newly inducted Fellow of the American College of Physicians.

Thomas Boswell of Tate participated in a panel discussion on child abuse for a conference-workshop for the public held April 2 in Pickens County.

DEATHS

William E. Campbell, Jr.

Retired ophthalmologist William E. Campbell, Jr., 82, died March 31, in Atlanta.

Dr. Campbell had practiced medicine in Atlanta 45 years and was a member of the staffs of Georgia Baptist Hospital and St. Joseph's Infirmary. He was born in Belton, S.C. and served in the U.S. Army during World War I. He was graduated from the University of Georgia, studied at Columbia Physicians and Surgeons Hospital in New York and interned at St. Luke's Hospital and the New York Eye Institute.

Dr. Campbell was a member of the American Academy of Ophthalmology and the Piedmont Driving Club.

He is survived by his widow, the former India Osborn; daughter, Mrs. Wharton Mitchell of Atlanta; and son, William E. Campbell, III of Greensboro, N.C.

Edwin M. Griffin

Edwin M. Griffin, a Bainbridge physician for 23 years, died March 9 following an illness of several months' duration. Dr. Griffin was born in Attapulgus, Georgia July 10, 1916, attended Georgia Southwestern College, Cornell University, at the University of Georgia and the Medical College of Georgia. His internship was served in Macon and he was a veteran of World War II.

Dr. Griffin was a charter member of the American Academy of Family Physicians and the Georgia Academy of Family Physicians and served on the staff of Memorial Hospital. He was a member of the First United Methodist Church in Bainbridge.

Survivors include his widow, Mrs. Evelyn Taunton Griffin; son Howard Griffin of Bainbridge; daughters, Mrs. Leesa Stewart of Atlanta and Miss Jena Griffin of Bainbridge; sister, nieces and nephews.

Sidney Terrell Parkerson

McRae family physician Sidney Terrell Parkerson died April 3 at the age of 72. The Dodge County native attended Locust Grove Institute and Mercer University, receiving his medical degree from the Medical College of Georgia. After serving his internship at Macon Hospital and Piedmont Hospital, he practiced in Uvalda before moving his practice in 1935 to McRae where he operated a private hospital until his death.

Dr. Parkerson was a member of the Rotary Club and First United Methodist where he had been a steward and trustee.

Survivors include his widow, Mrs. Mary Raby Parkerson; brothers and sisters.

American Medical Association 124th Annual Convention

Atlantic City, New Jersey — **June 14-19, 1975**

House of Delegates will convene at 1:30 p.m. Sunday, June 15 in the Grand Ballroom of the Chalfonte-Haddon Hall.

Postgraduate Courses will begin at 8 a.m., Saturday, June 14 at Convention Hall.

The Scientific Program opens at 8:30 a.m. June 14 and will close at 5 p.m. June 18.

The Scientific Exhibits will be housed in the Convention Hall and will be open June 14 through June 18 from 8:30 a.m. to 5 p.m.

Registration facilities will be outside the Grand Ballroom of the Chalfonte-Haddon Hall for delegates, alternate delegates, officers and directors of medical societies and invited guests. Others should register at the Convention Hall.

Among the special activities planned during the session will be the 1st National Conference on Mental Health Aspect of Sports, Exercise and Recreation. For the first time at an AMA convention, Category 1 Telecourses will be presented, and will be receivable on hotel televisions in the early evening.

The Woman's Auxiliary to the AMA will meet June 15-18. This year, joint programming with the Council on Scientific Assembly will feature a luncheon-panel discussion with Rene Dubos, Nobel laureate, on "Science and Ideals in a Hungry World." Other co-planned meetings include a program on Estate Planning for Physicians and Their Families and a session on Sexual Enrichment. Other guest speakers during the Auxiliary's session include George Plimpton, author and television personality, and Mary Louise Smith, Republican National Committee Chairman.

For additional information, contact the Medical Association of Georgia, WATS line 1-800-282-0224.

The Month in Washington

March saw the American Medical Association testify a number of times before numerous Congressional committees on a number of bills, including professional liability, extension of health insurance to the unemployed, comprehensive elementary and secondary school health education, and air pollution.

The House Ways and Means Subcommittee on Health began hearings in consideration of legislation for sweeping studies of the medical professional liability problem. The measure, sponsored by Subcommittee Chairman Dan Rostenkowski (D-Ill.) authorizes a study by the Office of Technology Assessment in conjunction with the National Academy of Sciences.

Under the proposal, one study would be completed within 90 days and consider interim arrangements for solution of problems relating specifically to Medicare and liability. The second study, with a 10-month schedule, would review the entire area of professional liability compensation.

In testimony before the Subcommittee, Malcolm Todd, M.D., AMA President, urged that remedial activity be undertaken at the state level.

Dr. Todd told the Subcommittee that personal injury lawsuits are determined under the state rules of law. He noted that the U.S. Constitution requires this procedure, "and as a consequence, each state can determine its own destiny and provide a wealth of experience—favorable or unfavorable—to its neighbors. Accordingly, the AMA is cooperating with our federated state societies in actively fostering discussion of professional liability law at the state level throughout America. We recognize that each state has its unique cultural, industrial, and social composition, and, accordingly, we expect to see a diverse response to the suggestions which we advance. However, we also expect to reap a rich experience by working within the system of American Federalism."

The AMA President said the federal government can be of assistance, but the ultimate responsibility is upon the states. "No one, least of all I suspect, within this Congress, wishes to see this situation deteriorate to such an extent that the federal government is required to intervene."

Dr. Todd urged specific language for the Professional Standards Review Organization program to avoid interpretation of the law as providing federal minimum standards of care. This would drastically increase defensive medicine, he warned.

Insurance for Unemployed

With respect to health insurance for the unemployed, Russell B. Roth, M.D., AMA's immediate past president, testified before the Rostenkowski subcommittee, that the current recession and inflation "have challenged the continued enjoyment of a way of life which we as a society so shortly ago assumed to be invulnerable."

The medical profession, Dr. Roth said, is committed to the goal of "reducing the human suffering increasingly prevalent throughout society."

The plight of the unemployed calls for fast remedial action "to devise a method under which health coverage is continued for the unemployed individual and his family and to afford such protection without disruption to the health delivery system." Dr. Roth advocated a temporary program which would, during the period of unemployment, continue the worker's insurance coverage for himself and his family. Such a program should be built upon the existing unemployment compensation system, one which affords a ready mechanism for implementation of a temporary program, according to Dr. Roth.

While the program would be funded from the general revenues of the federal government, premiums would be paid on the basis of certification of entitlement by state unemployment compensation agencies, he said.

A simple extension to the unemployed of Medicare Part A insurance coverage under the Medicare program would restrict the benefits to hospital care and any proposal which would condition the payment for services upon a hospital admission could only be expected to increase pressure for utilization of expensive care facilities and further aggravate inflationary costs, according to Dr. Roth.

"Moreover," Dr. Roth said, "the administration of a temporary health insurance program through the enlistment of the Medicare bureaucracy would place an immediate and intolerable burden upon an already strained bureaucracy."

The AMA presented similar testimony to the Senate Health Subcommittee headed by Senator Edward Kennedy (D-Mass.) which is holding hearings on the same subject.

Health Education Programs

The AMA has asked Congress to approve legislation to encourage comprehensive elementary and secondary school health education programs through a system of grants for teacher training, pilot and demonstration projects.

"The unfortunate fact is that most children and youths of the nation do not now have an opportunity to participate in comprehensive health education programs, since health education in many schools either is non-existent or is provided on a fragmented and inadequate basis," said Joe T. Nelson, M.D., a member of the AMA Board of Trustees.

Dr. Nelson told the House Education and Labor Committee: "The Comprehensive School Health Education Act can help build into the primary and secondary education of every American child a program of health instruction that will help establish patterns of living that we know will discourage disease and enhance health."

Air Pollution

Research on air pollution has proved that there can be health effects from long-term, low-level exposure, the AMA has told Congress. Episodes affecting large populations occur. Persons at high risk suffer more during periods of high pollution, and children may carry effects into adult life, William Barclay, M.D., AMA deputy executive vice president, testified.

Dr. Barclay told the House Health Subcommittee that the AMA House of Delegates has endorsed the present levels and time schedules promulgated by the Clean Air Act-1970, and encourages Congress to preserve present levels and time schedules as necessary public health measures.

Health Manpower Bill

Elsewhere on the Hill the House Health Subcommittee has approved a health manpower bill authorizing $1.7 billion over three years to support medical and other health profession education.

Under the proposal similar to the House-passed bill last year, medical schools would receive capitation support of $2,100 for each student for 1976 and 1977, with support decreasing to $2,000 per student in 1978. The bill provides a simple extension of present health manpower authority for this year.

Medical schools would be required to either increase their enrollment or provide for remote site training for at least 50 per cent of their students in their last two years of medical school education. Medical students would be required to pay back to the U.S. Treasury, capitation amounts paid to schools on their behalf, but would be given capitation payback forgiveness, on an equal year-for-year basis, for time spent in the National Health Service Corps or service in private practice in medically underserved areas.

Approved medical residencies could not exceed 155 per cent of the previous year's graduating class starting in 1978 as a restriction on foreign medical graduates. In 1979 and 1980, limitation would decrease to 140 per cent and 125 per cent. The Coordinating Council on Medical Education could administer the residency limitation, but if it does not agree to accept such administration, the government would do so.

Designated as primary care specialties would be general and internal medicine, pediatric medicine, family medicine, and obstetrics and gynecology.

Senator Edward Kennedy (D-Mass.) has introduced four bills dealing with health manpower, including his sweeping plan of last year calling for mandatory service and licensing and re-licensing. This was rejected in the last Congress by the Senate in favor of Senator J. Glenn Beall's (R-Md.) more limited plan. House and Senate could not reach agreement on the legislation last year.

Kennedy's health subcommittee will hold hearings on the four bills in a month or so.

NHI Talk

Despite President Ford's flat declaration that he would not introduce a national health insurance (NHI) proposal in the first session of the 94th Congress and would veto any such proposal, there is still talk of NHI this year by the Democratic leadership in both House and Senate.

During Dr. Russell Roth's testimony before Rep. Dan Rostenkowski's Ways and Means Health Subcommittee on health insurance for the unemployed, the Chicago Democrat said: "Whatever program (unemployed health insurance) may be enacted by Congress, we can expect that it will last until national health insurance goes into effect. The bills which have been introduced so far would phase out in a year or so. But as practical people, we know that any program we adopt will not be allowed to lapse until a permanent solution under national health insurance is in place. If we start a program with unemployment at nine per cent, we will not be able to phase it out should unemployment levels drop to four per cent—a figure we have not had in a long time. A program benefiting millions of people could hardly be arbitrarily cut off."

When his Subcommittee completes its work on the emergency problem, it will consider national health insurance. "The fact that we must do something about the immediate problem illustrates clearly the need to fashion a sound, workable plan of national health insurance for the long run, beginning next month, this Subcommittee will be working long hours to meet that goal," Rostenkowski said.

Utilization Review

HEW Secretary Caspar W. Weinberger has announced that the effective date for implementation of the utilization review regulations in hospitals and other health care facilities participating in the Medicare and Medicaid programs has been changed from February 1, 1975 to July 1, 1975.

"A number of questions about requirements and interpretation of the utilization review regulations have been raised since their publication, and some small rural hospitals have expressed concern about their ability to conform to these regulations," the Secretary said. "We have decided to move the effective date of the regulations so as to allow all providers to come into full compliance and to avoid the loss of eligibility to participate in the Medicare and Medicaid programs before July 1," he added. Secretary Weinberger said the Department would also use the time to work out special problems that may be faced in small rural hospitals.

Facilities with small medical staffs, especially those in rural areas, may have difficulty organizing the in-house review committees to operate the review system required by the regulations, the Secretary said. "For these facilities, several alternative means of complying with the law are provided in the regulations. State survey agencies and Departmental personnel will be available to work with the small facilities on these alternatives so that they can develop review systems that comply with the regulations."

Health Care Spending

Health care spending in the U.S. climbed over $100 billion for the first time in fiscal 1974, which ended last July 1. Public spending increased twice as fast as private spending.

A study, *National Health Expenditures,* published in a recent edition of the Social Security Bulletin, noted that the $104.2 billion health care bill represented a 10.6 per cent increase over the $94.2 billion spent in fiscal 1973.

Public spending amounted to $41.3 billion, or 39.6

per cent of the 1974 total, an increase of 15.3 per cent, or $5.5 billion. Private spending—mainly private insurance and out-of-pocket payments—accounted for $62.9 billion, or 60.4 per cent of the total health care expenditures for 1974. This was up 7.7 per cent, or $4.5 billion, over fiscal 1973.

Despite the dollar increases, health spending remained at the 1973 proportion of gross national product—7.7 per cent. Health spending averaged $485 per person. Hospital care was the largest expenditure category, amounting to $40.9 billion, or 39 per cent of the total. Physicians' services accounted for $19 billion, or 18 per cent. Expenditures for nursing home care reached an estimated $7.5 billion.

Of all personal health care spending in 1974, the government accounted for 38 per cent; private health insurance, 26 per cent; and philanthropic organizations, 1 per cent, out-of-pocket spending accounted for the remaining 35 per cent. Increases in Medicare and Medicaid expenditures accounted for most of the increase in the public share of health care expenditures.

Vitamin Legislation

The government has abandoned a long fight to classify high potency vitamins as drugs, bowing to opponents of vitamin legislation in Congress. Vitamin products will be available over-the-counter in any strength less than toxic, according to Food and Drug Administration officials. The Agency had hoped to require drug classification for vitamins exceeding 150 per cent of the recommended daily allowance. This and other proposed restrictions on vitamins had prompted a storm of protest to Congress from health food users and makers. The Senate last year voted 81 to 10 to prevent the FDA move. Court decisions had generally favored the FDA's right to impose restrictions on vitamin preparations, but the Agency recently decided to drop the hot potato. ■

EMORY PROGRAMS AVAILABLE ON VIDEO CASSETTES

The Georgia Regional Medical Television Network (GRMTN) is now videotaping and making available to physicians the Medical Conference, Cardiology Conference, Medical Grand Rounds and Pediatric Grand Rounds held weekly at Grady Memorial Hospital in Atlanta. In additional to the Emory University School of Medicine faculty, these conferences often include other internationally known guest lecturers.

These programs are now available on ¾ inch video cassettes for a charge of $300 per program per year, with approximately 50 tapes per year.

All programs are produced by the Division of Continuing Medical Education of Emory University School of Medicine and are fully accredited by the AMA Department of Continuing Medical Education for credit in categories 1 and 5 toward the Physician's Recognition Award. Details on how to use audiovisual material for credit are found in AMA publications.

This service is available to anyone in the United States. For additional information contact the GRMTN at 69 Butler St., S.E., Atlanta, Ga. 30303; telephone (404) 659-1212, ext. 762, or 659-5307.

Rondomycin®
(methacycline HCl)

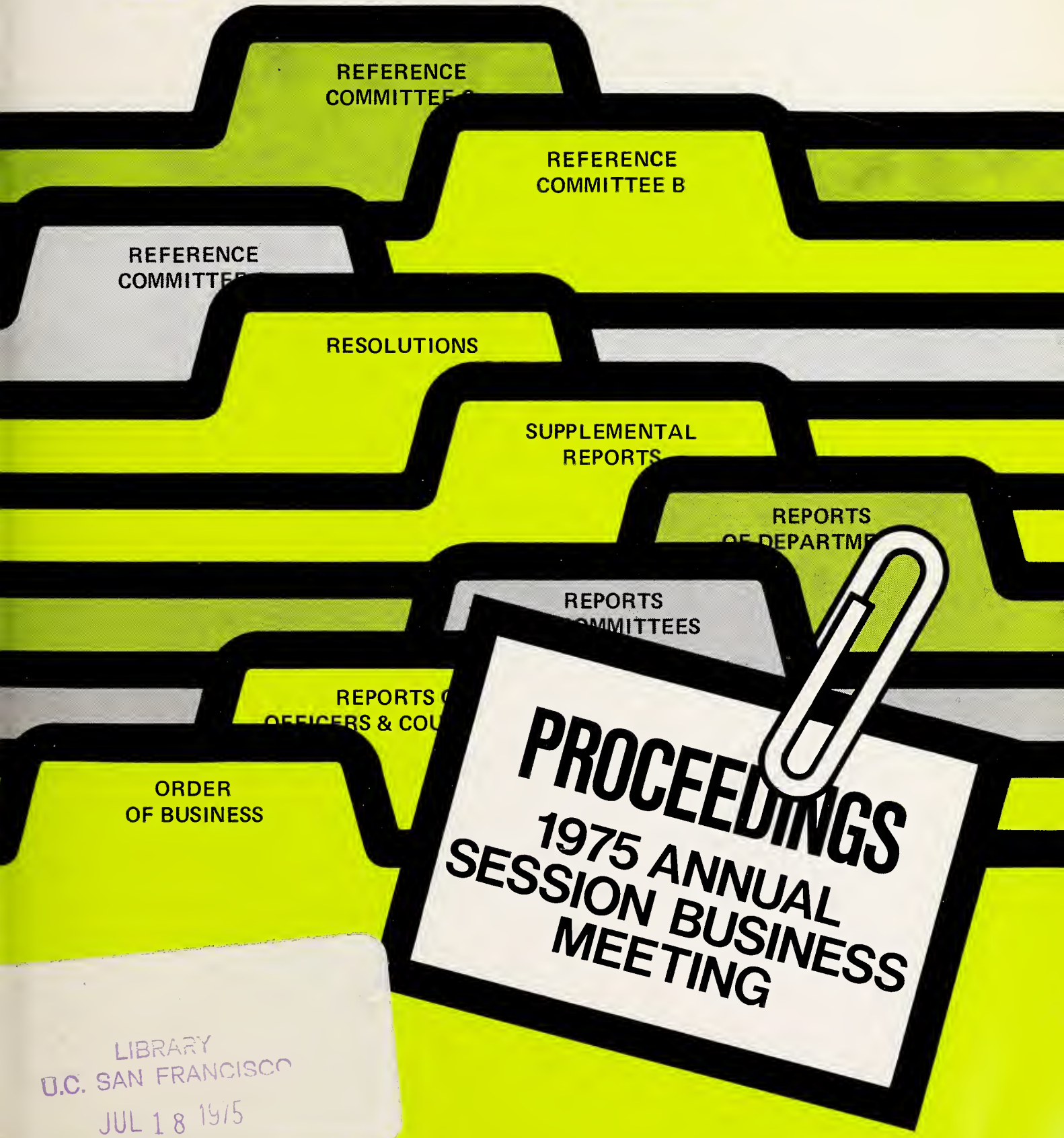
CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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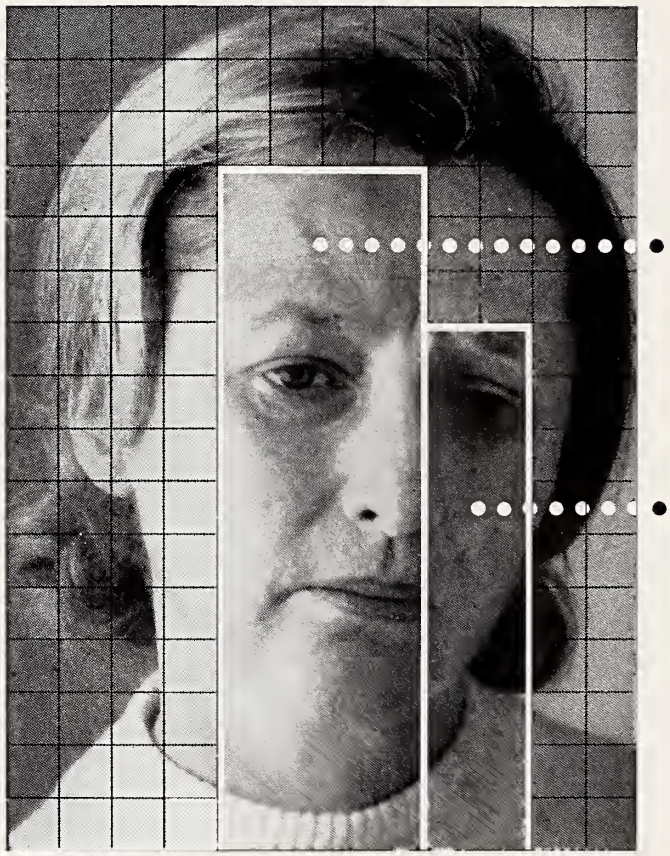
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freque and/or severity of grand mal seizures r require increased dosage of standard a convulsant medication; abrupt withdra may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous i gestion of alcohol and other CNS depre sants. Withdrawal symptoms (similar t those with barbiturates and alcohol) ha occurred following abrupt discontinuar (convulsions, tremor, abdominal and m cle cramps, vomiting and sweating). Ke addiction-prone individuals under care

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Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1975, Medical Association of Georgia.

Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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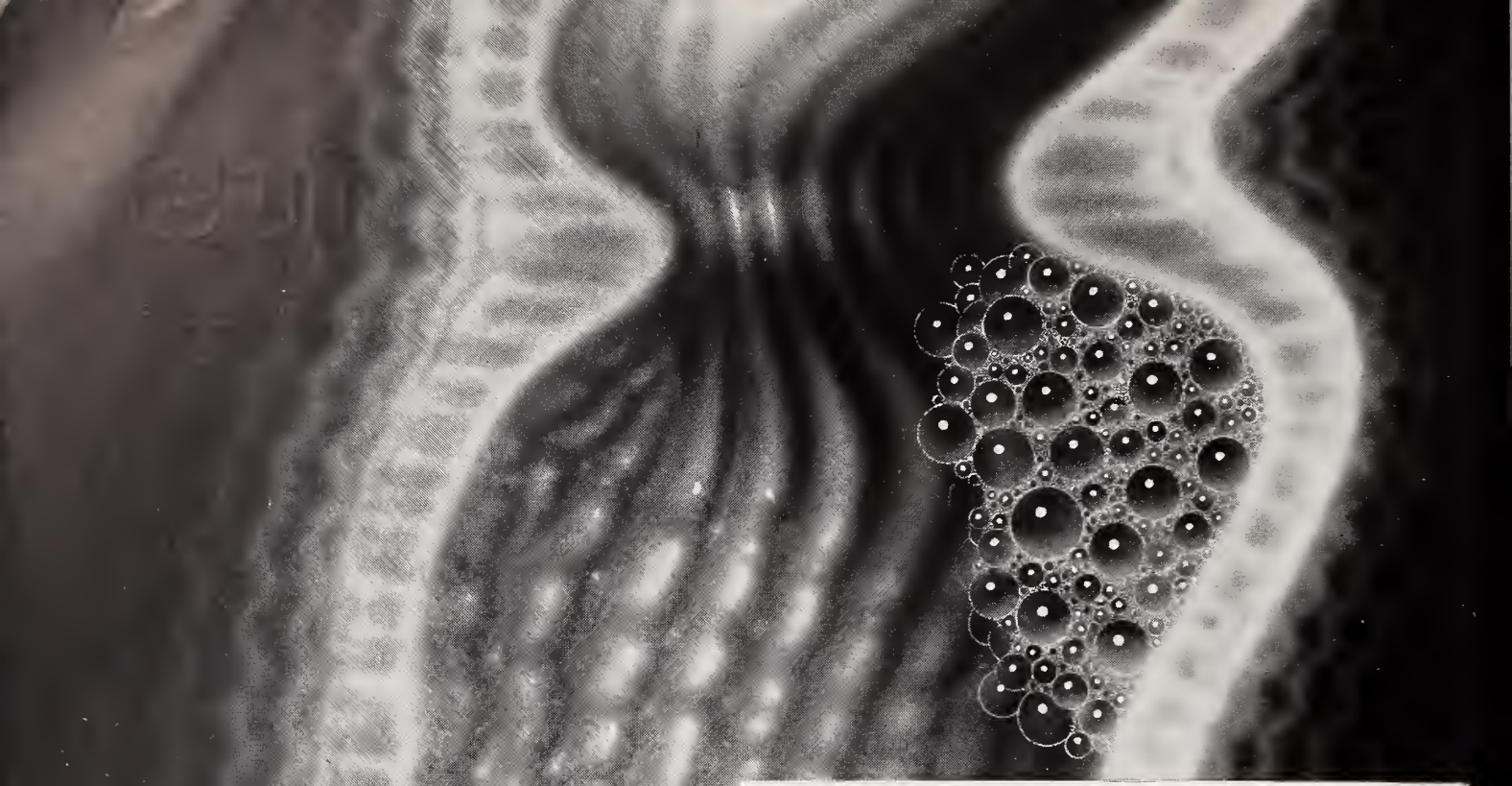
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Highlights of the 1975 Annual Session

THE 1975 ANNUAL SESSION Business Meeting of the Medical Association of Georgia was held at the Fairmont Colony Square Hotel in Atlanta, April 18-20. The total attendance, including delegates, members, Woman's Auxiliary and guests, was 461.

Participants at the second annual GaMPAC brunch heard an address by Governor George D. Busbee. Governor Busbee told the group of his intention to establish a study commission to review the malpractice insurance situation in Georgia. The commission will be composed of representatives of MAG, the Georgia Hospital Association, the Georgia Bar Association and the public. The commission will make a report to the Governor who will then take appropriate action to resolve problems that exist.

A full review of all reports and resolutions presented to the 1975 House of Delegates follows these highlights, as well as the recommendations of reference committees and subsequent House actions.

Awards

W. A. Mendenhall of Chamblee was selected as Family Physician of the Year; Robert H. Smoot of DeKalb County was awarded the Civic Endeavor Award and Perry P. Volpitto of Augusta was presented the Distinguished Service Award.

Officers

David A. Wells of Dalton was installed as president, J. Rhodes Haverty of Atlanta as immediate past president and Fleming L. Jolley of Atlanta as president-elect. Other officers either installed or elected were: W. Daniel Jordan of Atlanta as first vice president; James H. Sullivan of Columbus as second vice president; Earnest C. Atkins of Decatur as secretary; Carson B. Burgstiner of Savannah as treasurer; AMA Delegates—C. Emory Bohler of Brooklet and F. William Dowda of Atlanta; AMA Alternate Delegates—F. G. Eldridge of Valdosta, Charles D. Hollis of Albany and H. Hilt Hammett of LaGrange.

Special House elections were held for councilor and vice councilor positions in the Ninth and Tenth Districts. The results of those elections were: Ninth District—Harvey M. Newman, Gainesville, councilor and L. Austin Flint, Canton, vice councilor; Tenth District—Edwin W. Allen, Jr., Milledgeville, councilor and M. A. Hubert, Athens, vice councilor.

PSRO

The House of Delegates reviewed the PSRO situation for the third time. After lengthy reference committee and floor debate it was decided that MAG, through its appropriate subsidiary should apply for a PSRO planning contract 15 days prior to the deadline for physicians to receive priority consideration for a contract.

The House also voted to, in cooperation with the AMA, seek amendments to the PSRO law to remove its most onerous parts.

Access to Health Care

The House voted to continue its support of the Georgia State Medical Education Board. It also voted that MAG should endorse efforts to produce more family practice physicians and, if necessary, to support legislative action to fund more family practice residency programs for the state.

Education

The following were among recommendations approved from the Education Committee report: MAG should become more active in community hospital education programs; MAG should encourage more organizations to apply for accreditation through MAG and AMA; MAG should promote medical audit as a method to determine educational needs in community hospitals.

Organization and Functions

This committee had recommended sweeping changes in the MAG organizational structure including: reducing the number of members on the council, changing the name of the Council to Board of Directors, eliminating the two vice presidential officers. By action of the House, all these measures will be referred back to the committee for further developmental work.

Membership

Within the report of the Secretary was a recommendation to create a unified membership plan at the state level. This would have required new members to first join MAG, then the county society. The House voted to table this recommendation for future action.

It was also noted that no call for a dues increase

had been made for this year but the prospects for an increase existed for the future.

Georgia Medical Care Foundation

The House voted to endorse the CHEC program on a statewide basis. This subject was also addressed under the report of the Ad Hoc Committee to Study Peer Review Mechanisms. The reference committee that reviewed this report recommended the evaluation of concurrent review also be developed in the CHEC program.

Peer Review Mechanisms

In addition to the CHEC recommendation above, the House recommended the endorsement of the Medical Care Evaluation (MCE) system of medical audit. This system is being developed through the MAG research and development department.

Insurance and Economics

The House took special note of the new claims made procedure for malpractice coverage being employed by our insurance carrier. The insurance and economics committee and the MAG council were directed to pursue every reasonable means to obtain a more desirable form of professional liability coverage.

Communications

The House voted to encourage the president and president-elect to divide the state in an appropriate fashion for the purpose of visiting county medical societies and news media outlets during their term of office.

Also approved was having the communications committee serve as the coordinating committee for all committees in dealing with matters of public interest.

Future Meetings

The dates and sites of future Annual Business Session meetings are:

1976 (April 9-11) Jekyll Island
1977 (April 22-24) Macon
1978 (April 21-23) Augusta
1979 (April 20-22) Savannah

ALUMNI NIGHT AT SCIENTIFIC ASSEMBLY

Friday, November 21, will be alumni night at MAG's 1975 Scientific Assembly, to be held at the Terrace Garden Inn opposite Lenox Square in Atlanta. The evening has been set aside for such alumni activities as receptions and banquets. Groups already planning functions are the Medical College of Georgia's Class of '45 and the Tulane Medical School alumni.

If your alumni group is interested in getting together at the Scientific Assembly, please contact Stephen Daniel, Ph.D., Coordinator, MAG Scientific Assembly, 938 Peachtree St., N.E., Atlanta 30309. Tel.: (404) 876-7535 or 1-800-282-0224 (WATS).

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MAG First General Session

1975 Annual Session Business Meeting
Friday, April 18, 1975

The First General Session of the 1975 Annual Session Business Meeting of the Medical Association of Georgia was called to order by President J. Rhodes Haverty, M.D., Atlanta, at 9:15 a.m. in the Ballroom of the Fairmont Colony Square Hotel, Atlanta, Georgia, on April 18, 1975.

Dr. Haverty welcomed all those present and called upon the Reverend Allison Williams, Pastor of the Trinity Presbyterian Church, Atlanta, for the invocation.

Following the invocation, Ronald F. Galloway, M.D., Augusta, led the assembly in the pledge of allegiance to the flag.

President Haverty called on Mrs. William H. Benson of Marietta to lead the group in a memorial service to our departed colleagues and to physicians' wives who had died since the 1974 Annual Session. They were as follows:

MAG Deceased Members

Claude A. Almand, Lithonia, Oct. 4, 1974
W. C. Baxley, Blakely, June 6, 1974
William G. Brawley, Decatur, May 22, 1974
Samuel Y. Brown, Atlanta, Oct. 4, 1974
James R. Bryan, Augusta, Dec. 12, 1974
B. Russell Burke, Atlanta, Sept. 18, 1974
William E. Campbell, Jr., Atlanta, March 31, 1975
William Franklin Castellow, Americus, Feb. 25, 1975
Harold R. Collier, Savannah, Feb. 9, 1975
J. J. Collins, Thomasville, Dec. 28, 1974
C. Walter Coolidge, Atlanta, Dec. 28, 1974
John M. Dent, Jr., Tifton, Oct. 4, 1974
George P. Dillard, Atlanta, Oct. 25, 1974
Herbert M. Edge, Blairsville, May 31, 1974
W. G. Elliott, Cuthbert, May 12, 1974
Charles H. Field, Macon, May 11, 1974
Edwin M. Griffin, Bainbridge, March 9, 1975
H. E. Griggs, Conyers, April 22, 1974
Lawton Quinby Hair, Augusta, Dec. 14, 1974
Earl W. Hathcock, Atlanta, July 31, 1974
Ralph N. Johnson, Rome, Jan. 20, 1972
Charles S. Jones, Atlanta, June 7, 1974
E. C. Jungck, Augusta, July 17, 1974
Lewell S. King, College Park, Aug. 19, 1974
J. H. Lamm, Macon, June 23, 1974
Frederic R. Minnich, Atlanta, May 19, 1974
Hugh G. Mosley, Sr., Atlanta, Jan. 29, 1975
F. W. Morgan, Douglasville, June 15, 1973
Jack C. Norris, Atlanta, June 22, 1974
William W. Puett, Norcross, Jan. 12, 1975
W. B. Quillian, Jr., Cartersville, Jan. 28, 1975
David E. Quinn, Dublin, Sept. 29, 1974
Charles Shorter, Atlanta, June 7, 1974
Joel P. Smith, Sr., Atlanta, March 3, 1975
John E. Smith, Fitzgerald, Jan. 12, 1975



As the memorial service is read by Mrs. William H. Benson and James H. Manning, M.D. of Marietta, carnations for each Auxiliary and MAG deceased member of the past year are pressed by Mrs. Bob Maughon of Columbus into a floral wreath steadied by Mrs. George W. Statham of Decatur.

J. K. Stalvey, Jr., Savannah, June 14, 1974
Robert G. Stephens, Washington, Aug. 1974
Bernard Strickman, Atlanta, Feb. 5, 1975
Hart Sylvester, Hawkinsville, April 28, 1974
Bruce Threatte, Columbus, Sept. 16, 1974
J. J. A. Viera-Zafra, Columbus, Feb. 11, 1975
Harold Whiteman, Atlanta, Nov. 15, 1974
Edward S. Wright, Atlanta, Sept. 6, 1974
Francis M. Zeigler, Albany, Nov. 2, 1974

Auxiliary Deceased Members

Mrs. Joseph M. Almand, Jr., LaGrange
Mrs. Warren G. Coleman, Eastman (Past State President)
Mrs. C. B. Elliott, Cuthbert
Mrs. John C. Mitchell, Augusta
Mrs. John W. Mobley, Thomasville
Mrs. W. T. Smith, Tifton
Mrs. Henry E. Steadman, Atlanta
Mrs. Bryon H. Steele, Fairmont

Following the memorial service, President Haverty introduced Mr. Wyche Fowler, President of the Atlanta City Council, to officially welcome the Medical Association of Georgia meeting to Atlanta.



Atlanta City Council President Wyche Fowler welcomes MAG delegates to the city and expresses the public's appreciation of the medical profession. "Whenever man is ravaged or captured by disease, he is never free," Fowler tells the group.

Mr. Fowler was followed by William D. Logan, President of the Medical Association of Atlanta, who extended greetings from the host medical society to the assembly.

President Haverty acknowledged the presence of several guests and asked them to stand to be recognized. They were: Mr. Ewing F. Barnett, President, Georgia Hospital Association; Dr. Larry Winsberg, Immediate Past President, Georgia Podiatry Association; Dr. W. E. Butlin, President, Georgia Podiatry Association; Mr. Sam Thurmond, state Medicaid Director; Mr. Robert Boring, Georgia State Chairman of the Health Insurance Association of America; Mr. Edward J. Bonn, President-Elect, Georgia Nursing Home Association; and Mr. William L. James, Vice President, Atlanta Blue Cross.

At this point, Dr. Haverty introduced Mrs. George I. Harrison of Marietta, President of the Woman's Auxiliary to the Medical Association of Georgia. Mrs. Harrison gave a report on the activities of the Auxiliary and then introduced a special guest, Mrs. Earle E. Wilkinson, Nashville, Tennessee, President-Elect of the Woman's Auxiliary to the American Medical Association. Mrs. Wilkinson extended greetings from the AMA Auxiliary and gave a brief report on their activities.

President Haverty called on David A. Wells, M.D., of Dalton, President-Elect of the Medical Association of Georgia, to deliver the address of the incoming President of the Association.

Following Dr. Wells' talk, President Haverty proceeded with several program announcements including the special open forum on the medical disciplinary investigation procedure scheduled for Friday afternoon, the GaMPAC brunch at which Governor George Busbee would speak scheduled for Saturday morning and the President's Reception scheduled for Saturday night.

At this point, President Haverty recessed the First General Session and announced that the First Session of the House of Delegates would be convened in approximately five minutes.

First Session House of Delegates

Friday, April 18, 1975

The First Session of the House of Delegates was called to order by Speaker L. C. Buchanan at 10:15 a.m. in the Ballroom of the Fairmont Colony Square Hotel, Atlanta, Georgia, on Friday, April 18, 1975. The Speaker extended greetings to all delegates and briefly outlined the responsibilities of the House during its two sessions on April 18 and 20, 1975.

Speaker Buchanan called for a report of the delegates in attendance. Thomas G. Douglass, M.D., Augusta, Chairman of the Credentials Committee, reported that there were 132 duly elected delegates representing 40 component county medical societies present and, accordingly, announced that a quorum of the House was present. (A later tally of the Credentials Committee indicated 137 delegates were present at the First Session.)

Attendance

BALDWIN: Edwin W. Allen, Jr. and W. T. Smith; BARTOW: R. A. Griffin, III; BIBB: Jimmy Asbell, Rodney Browne, John G. Etheridge, Warren Griffin, Jasper T. Hogan, Jr., Jack F. Menendez, Beverly B. Sanders; OGEECHEE RIVER: Leon E. Curry; CARROLL-DOUGLAS-HARALSON: Clark Robinson; GEORGIA MEDICAL SOCIETY: Carson B. Burgstiner, J. Patrick Evans, Frank M. Johnston, Debele Maner, Joseph V. Morrison, Dearing A. Nash; CHATTAHOOCHEE: Rupert H. Bramblett and Cecil L. Miller; CHEROKEE-PICKENS: L. Austin Flint; CLAYTON-FAYETTE: Selwyn T. Hartley; COBB: Robert P. Coggins, Philip Israel, Bruce Kyburz, James H. Manning, J. Gary Palmer, Harry Porter, Jr., Charles J. Rey and Dan B. Stephens; COLQUITT: John P. Tucker; DEKALB: Stanley P. Aldridge, Duane Blair, L. C. Buchanan, L. L. Freeman, John P. Heard, James C. Joiner, Charles McDowell, LaMar S. McGinnis, Richard Smoot, Ralph A. Tillman and Roy Vandiver; DOUGHERTY: J. D. Bateman, D. M. Boyette, Charles D. Hollis and Robert D. Waller; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD-POLK-CHATOOGA: Jack R. Meacham, C. O. Sennett and James H. Smith; FRANKLIN-HART: J. Weldon Williams, Jr.; MEDICAL ASSOCIATION OF ATLANTA: Thomas J. Anderson, John S. Atwater, Linton H. Bishop, E. Napier Burson, William C. Collins, Brown W. Dennis, F. W. Dowda, Edwin C. Evans, Louis H. Felder, Joseph L. Girardeau, Charles E. Harrison, J. Harold Harrison, John Rhodes Haverty, William Huger, Jr., Fleming L. Jolley, W. D. Jordan, James A. Kaufmann, William D. Logan, John R. McCain, William W. Moore, C. R. Moorhead, Keith A. Quarterman, Harrison L. Rogers, John K. Schellack, William B. Spearman, T. L. Tidmore, L. Newton Turk, B. F. Voljavec, William C. Waters, III, Robert E. Wells, Frank L. Wilson and Joseph S. Wilson; GLYNN: M. A. Glucksman, Edwin A. Mayo and W. Jack Smith; GORDON: R. D. Walter; HABERSHAM: Thomas N. Lumsden; HALL: Lawrence L. Durisch, John W. Garland, III and Harvey Newman; PEACHBELT: H. E. Weems, Jr.; LAURENS: O. B. Johnson and Robert W. Oliver; MCDUFFIE: Thomas E. Averitt; MUSCOGEE: John H. Deaton, Bob R. Maughon, E. M. Molnar, Bruce C. Newsom, Jack A. Raines and James H. Sullivan; NEWTON-ROCKDALE: Ragilio Bonau; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Joseph P. Bailey, Jr., William E. Barfield, Claud A. Boyd, Albert A. Carr, Thomas G. Douglass, Julius T. Johnson, John M. Martin, Ronald F. Galloway, J. Kenneth McDonald, John Phinizy, Stuart Prather, Luther M. Thomas, Jr., Betty B. Wray and Charles H. Wray; SOUTH GEORGIA MEDICAL SOCIETY: F. G. Eldridge and Joe C. Stubbs; SPALDING: Henry A. Foster and James Skinner; ST. JOHN'S PARRISH: Whitman Fraser; STEPHENS-RABUN: Irving Hellenga and C. Peter Lampros; SUMTER: E. W. Waldemayer; THOMAS AREA: F. R. Miller and Gerald B. Muller; TIFT: Robley D. Smith; TROUP: J. M. Almand and H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Ted D. Cash and M. K. Cureton; WARE: Floyd Davis; WHITFIELD-MURRAY: John G. Forshner and James J. Oosterhoudt.

Speaker Buchanan thanked the Chairman of the Credentials Committee for his report; presented Ronald F. Galloway, M.D., Augusta, Vice Speaker of the House and, subsequently, explained in detail the methods for consideration of business that would be brought before the House of Delegates.

The Speaker then announced the appointment of the House of Delegates Credentials Committee and the Tellers Committee as follows:

CREDENTIALS COMMITTEE: Thomas G. Douglass, Augusta, chairman; John G. Forshner, Dalton; J. Patrick Evans, Savannah.

TELLERS COMMITTEE: Thomas J. Anderson, Jr., Atlanta, chairman; Walter R. Voyles, Waynesboro; Rodney Browne, Macon.

The Speaker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE A: Robert W. Oliver, Dublin, chairman; J. Kenneth McDonald, Augusta, vice chairman; Richard H. Smoot, Decatur; Clark Robinson, Douglasville; L. L. Durisch, Gainesville; Keith A. Quarterman, Atlanta.

REFERENCE COMMITTEE B: William C. Waters,

III, Atlanta, chairman; Jack A. Raines, Columbus, vice chairman; John G. Bates, Cuthbert; Roy Vandiver, Decatur; Harry Porter, Jr., Smyrna; Thomas N. Lumsden, Clarksville.

REFERENCE COMMITTEE C: Joseph P. Bailey, Augusta, chairman; Robert E. Jennings, Arlington, vice chairman; Daniel B. Stephens, Marietta; Samuel M. Goodrich, Milledgeville; James R. Meacham, Summerville; Joseph L. Girardeau, Atlanta.

REFERENCE COMMITTEE D: H. Hilt Hammett, LaGrange, chairman; Jasper T. Hogan, Macon, vice chairman; Harvey M. Newman, Gainesville; Joseph S. Wilson, Atlanta; Joseph A. Mulherin, Savannah; Robley D. Smith, Tifton.

REFERENCE COMMITTEE F: Duane Blair, Decatur, chairman; Stuart Prather, Augusta, vice chairman; James H. Manning, Marietta; John S. Atwater, Atlanta; James H. Sullivan, Columbus; Robert D. Waller, Albany.

The Speaker announced that the proceedings of the 1974 Annual Session had been published in the June 1974 issue of the *Journal of the Medical Association of Georgia* and called for any corrections that should be made. There were none and he called for a motion for approval of these proceedings as published. On motion duly made and seconded, it was voted that these minutes be approved as published.

Nominations

Speaker Buchanan called on the House to proceed with the nominations of officers, AMA delegates and alternates, councilors and vice-councilors. He requested that the nominating speeches be limited to two minutes and seconding speeches be limited to one minute.

The Speaker asked for nominations for the office of MAG president-elect and the following nomination was made:

PRESIDENT-ELECT: Fleming L. Jolley, Atlanta, nominated by George H. Alexander. Dr. Jolley's candidacy was seconded by W. D. Logan and James Smith. There being no further nominations for the office of president-elect, the nominations were closed.

SECOND VICE PRESIDENT: James H. Sullivan, Columbus, was nominated for the office of second vice president by Bruce C. Newsom. Dr. Sullivan's candidacy was seconded by J. W. Chambers, John R. McCain, John M. Martin, J. Gary Palmer, Robert D. Waller, Frank Johnson, John G. Bates and James J. Oosterhoudt.

John P. Heard, Decatur, was nominated by Charles M. McDowell. Dr. Heard's candidacy was seconded by Thomas G. Douglass, Linton H. Bishop, William Huger, R. D. Walter, Earnest C. Atkins, Rupert H. Bramblett, Jack Menendez, Leon Curry and Duane Blair.

There being no further nominations for the office of MAG Second Vice President, the nominations were closed.

The Speaker asked for nominations for the office of Secretary.

SECRETARY: Earnest C. Atkins, M.D., Decatur, was nominated by F. G. Eldridge, Valdosta. Dr. Atkins' candidacy was seconded by Duane Blair and J. Harold Harrison.

There being no further nominations for the office of Secretary, the nominations were closed.

The Speaker asked for nominations for the office of Treasurer.

TREASURER: Carson B. Burgstiner, M.D., Savannah, was nominated by John Kirk Train. Dr. Burgstiner's candidacy was seconded by John S. Atwater, J. W. Chambers and C. E. Bohler.

There being no further nominations for the office of Treasurer, the nominations were closed.

AMA Delegates

Speaker Buchanan called for nominations for delegates to the American Medical Association. He observed that the terms of all new delegates would begin on January 1, 1976.

AMA DELEGATE: For the office held by J. W. Chambers, LaGrange, C. E. Bohler, M.D., Brooklet, was nominated by Leon Curry. Dr. Bohler's candidacy was seconded by Ronald F. Galloway and John Kirk Train.

There being no further nominations for this office, the nominations were closed.

At this point, C. E. Bohler, M.D., offered his resignation as AMA Alternate Delegate, effective December 31, 1975.

AMA DELEGATE: For the office held by John S. Atwater, F. William Dowda, M.D., Atlanta, was nominated by Harrison L. Rogers. Dr. Dowda's candidacy was seconded by John S. Atwater, Robert Coggins, Weldon Williams, Joe C. Stubbs, Frank Miller and Thomas L. Tidmore.

Luther M. Vinton, M.D., Avondale Estates, was nominated by LaMar S. McGinnis. Dr. Vinton's candidacy was seconded by Stuart Prather, Earnest C. Atkins and Robert Waller.

There being no further nominations for this office, the nominations were closed.

At this point, F. William Dowda, M.D., offered his resignation as AMA Alternate Delegate, effective December 31, 1975.

The Speaker asked for nominations for the office of alternate delegate to the American Medical Association.

AMA ALTERNATE DELEGATE: For the office held by F. G. Eldridge, M.D., F. G. Eldridge, M.D., Valdosta, was nominated by Charles R. Andrews. Dr. Eldridge's candidacy was seconded by Joe C. Stubbs.

There being no further nominations for this office, the nominations were closed.

AMA ALTERNATE DELEGATE: For the office held by Luther M. Vinton, Charles D. Hollis, M.D., Albany, was nominated by Robert Waller. Dr. Hollis' candidacy was seconded by Edwin C. Evans, Bruce Newsom and Charles Underwood.

John P. Heard, M.D., Decatur, was nominated by Charles McDowell. Dr. Heard's candidacy was seconded by Thomas G. Douglass.

There being no further nominations for this office, the nominations were closed.

AMA ALTERNATE DELEGATE: For the office

held by C. E. Bohler, H. Hilt Hammett, M.D., LaGrange, was nominated by Joseph Almand. Dr. Hammett's candidacy was seconded by Edwin C. Evans, T. A. Sappington and Ronald F. Galloway.

There being no further nominations for this office, the nominations were closed.

AMA ALTERNATE DELEGATE: For the office held by F. William Dowda, William W. Moore, M.D., Atlanta, was nominated by J. Harold Harrison. Dr. Moore's candidacy was seconded by Jack Raines and Fleming L. Jolley.

There being no further nominations for this office, the nominations were closed.

At this point, it was announced by the Speaker that Dr. Dowda had announced his intention to resign this position effective December 31, 1975.

Councilors and Vice Councilors

Speaker Buchanan announced that the Ninth and Tenth District Medical Societies had not elected their councilors and vice-councilors according to Chapter V, Section 2, of the Bylaws as their annual meetings had not been held prior to the Annual Session. Accordingly, he announced that the election of Ninth and Tenth District councilors and vice-councilors would be done by the House of Delegates pursuant to the Bylaws.

The Speaker then recognized John Garland, M.D., Gainesville, for the purpose of nominating a candidate for the office of Ninth District councilor and for Ninth District vice-councilor. Dr. Garland placed in nomination for those two offices Harvey M. Newman, M.D., Gainesville, for councilor and L. Austin Flint, M.D., Canton, for vice-councilor.

There being no further nominations for the office, the nominations were closed.

Vice Speaker then recognized W. T. Smith, M.D., Milledgeville, for the purpose of nominating a candidate for the office of Tenth District councilor and Tenth District vice-councilor. Dr. Smith placed in nomination Edwin C. Allen, M.D., Milledgeville, for councilor and M. A. Hubert, M.D., Athens, for vice-councilor.

There being no further nominations for the office, the nominations were closed.

Dr. Galloway then announced the results of the elections for councilor and vice-councilor as conducted by the component medical societies. These were:

Bibb County Medical Society Councilor: Milton I. Johnson, M.D., Macon (1978); Vice Councilor: Beverly B. Sanders, M.D., Macon (1978).

Cobb County Medical Society Councilor: Charles R. Underwood, M.D., Marietta (1978); Vice Councilor: Frank W. McKinnon, M.D., Marietta (1978).

DeKalb County Medical Society Councilor: Luther M. Vinton, M.D., Avondale Estates (1978); Vice Councilor: Stanley P. Aldridge, M.D., Decatur (1978).

Floyd-Polk-Chattooga Medical Society Councilor: John I. Dickinson, M.D., Rome (1978); Vice Councilor: Lee H. Battle, M.D., Rome (1978).

Medical Association of Atlanta Councilor: Fleming L. Jolley, M.D., Atlanta (1978); Vice Councilor: T. J. Anderson, M.D., Atlanta (1978).

Richmond County Medical Society Councilor: Ronald F. Galloway, M.D., Augusta (1978); Vice Councilor: Henry D. Scoggins, M.D., Augusta (1978).

Annual Reports

Speaker Buchanan called for the Annual Reports of MAG officers, Council, councilors, vice-councilors, AMA delegates, Association committees and other reports to be introduced at this session, which are listed below with the Reference Committee to which these reports were referred, appropriately indicated. (Editorial Note: The complete report, the action of the Reference Committee and the subsequent action taken by the House of Delegates on each report referred to a Reference Committee will be found under the proceedings of the Second Session of the House of Delegates. See pages 182-242.)

OFFICERS

President—Reference Committee A
President-Elect—B
Second Vice President—F
Secretary—A
- Recommendation 1—F
- Recommendation 2—A
- Recommendation 3—A
- Recommendation 4—A
- Recommendation 5—D
- Recommendation 6—A

Treasurer—Not Referred
Speaker of the House—Not Referred
Delegate to AMA—A

COUNCILORS AND VICE COUNCILORS

Chairman of Council—A
- Recommendation 1—D
- Recommendation 2—A
- Recommendation 3—F

First District Councilor—Not Referred
Second District Councilor—Not Referred
Third District Councilor—A
Sixth District Councilor—Not Referred
Seventh District Councilor—F
Eighth District Councilor—Not Referred
Ninth District Councilor—Not Referred
Tenth District Councilor—Not Referred
Bibb County Councilor—A
- Recommendation 1—B
- Recommendation 2—B
- Recommendation 3—A
- Recommendation 4—B
- Recommendation 5—D

Cobb County Councilor—Not Referred
DeKalb County Councilor—Not Referred
Georgia Medical Society Councilor—C
MAA Councilor—Not Referred
Muscogee County Councilor—Not Referred
Richmond County Councilor—D
Council Supplemental Report (O/C 9)—F
Council Supplemental Report (Budget)—F

ASSOCIATION COMMITTEES

Annual Session—Reference Committee C
Constitution and Bylaws—D
Constitution of Bylaws Supplemental Report—D
Cancer—Not Referred

Emergency Medical Services—Not Referred
Access to Health Care—A
Recommendation 1—F
Recommendation 2—A
Recommendation 3—A
Recommendation 4—A
Communications—A
Education—C
Insurance and Economics—Not Referred
Legislation—National—Not Referred
Quackery—D
Maternal and Infant Welfare—C
Mental Health—Not Referred
Occupational Health—Not Referred
Professional Conduct and Medical Ethics—Not Referred
PSRO—B
Rural Health—Not Referred
Public Health—C
Rural Health—Not Referred
Interspecialty Council—Not Referred
Ad Hoc Committee to Study Physicians' Assistants—C
Ad Hoc Committee on Organization and Functions—D
Ad Hoc Committee to Evaluate Peer Review Mechanisms—B
Ad Hoc Committee on Laboratory Quality—C
School Child Health—Not Referred
Private Practice—Not Referred
EMCRO—B
PSRO Supplemental Report—B

SPECIAL REPORTS

Georgia Medical Care Foundation—Reference Committee B
Georgia Regional Medical Program—Not Referred
Journal—Not Referred
Woman's Auxiliary to the MAG—D
Recommendation 1—D
Recommendation 2—D
Recommendation 3—F
Recommendation 4—F
Recommendation 5—F

The Speaker called attention to the reports which are shown as having no recommendations and thus had not been referred to any Reference Committee. He told the delegates that they could request that any reports be referred and a request from a delegate to refer the Annual Report of the Committee on Insurance and Economics was made. Accordingly, the Speaker referred this report to Reference Committee D. The Speaker then announced that all reports not referred to committees would be filed for information. They are as follows:

TREASURER

Carson B. Burgstiner, M.D.

It is again my privilege to serve the Medical Association of Georgia as your Treasurer for the years 1974-75, an honor indeed to serve with my fellow physicians, who endeavor to conduct the business of this association. My heartfelt thanks to the dedicated staff who make our contributions more efficient and effective.

The MAG is in good, sound financial condition. Despite rising costs, spiralling inflation, decreasing interest rates, recession and a pessimistic national outlook, our income has been sufficient to meet the needs of the Association. We have had an increase in membership with resulting increase in dues income.

The money earned on interest investments has been phenomenal. For this contribution we can thank Mr. L. B. Storey, our Director of Finance and Dr. Tex Eldridge, our Chairman of Finance. I must confess that I continue to get great advice from the old "Tightwad" himself, Dr. John S. Atwater. These men, along with the Finance Committee and Treasurer, have continued to enhance the financial position of the MAG. Many thanks to Dr. Rhodes Haverty for his "think tank" and reorganization planning Session at Unicoi. Many useful ideas have come out of that meeting, which will result in a better organized, more efficient and active MAG. I welcome the new additions to the staff, Dr. Stephen Daniel, the Director of Continuing Education, and Mr. J. Sherwood Williams, the Director of Administration. They will take a great time burden off of Jim Moffett, enabling our association to use his expertise as Executive Director more effectively.

My appreciation to Dr. Earnest Atkins for his untiring efforts to unify our association. Bless Mrs. Catherine Wooten for her often unrewarded efforts to bring the loose ends together. We really appreciate her sincere interest.

A special thanks to Mr. L. B. Storey, our financial expert, who has proven his dedication to our association.

In closing let me again challenge you to do something nice for yourself, become ACTIVE, support your Medical Association of Georgia with your time, your advice and your financial contributions.

SPEAKER OF THE HOUSE OF DELEGATES

Leslie C. Buchanan, M.D.

Since assuming office at the conclusion of the 1974 Annual Session, the Speaker of the House has faithfully attempted to represent the will and directives of the House of Delegates at the meetings of Executive Committee, MAG Council, the Unicoi Planning Conference, Board Meetings of the GMCF and various MAG committee meetings. On these occasions the Speaker has addressed such issues, raised such questions, and challenged some proposals when it seemed appropriate to do so in the interest of continuing House of Delegates policy and philosophies.

Certain specific issues were considered at the 1974 Annual Session of the House of Delegates, viz.,

I. **Access to Health Care**
Pursuant to 1974 House directive, the Executive Committee did act to insure that a continuing Special Committee on Access to Health Care become an ongoing part of MAG organization. This was accomplished by June 1974. That Committee has been active and its report is in your Handbook.

II. **Employment of an Education Coordinator**
Staff followed the specifications regarding salary, job description, etc., laid down by the House,

and the Executive Committee accomplished this directive in the employment of Stephen Daniel, Ph.D. for the position which he assumed on October 1, 1974. Dr. Daniel will staff Reference Committee "C" at this Annual Session.

III. **Formation of Finance Committee of House of Delegates**

At its January, 1975 meeting MAG Council did comply with House directives regarding this issue, setting a maximum limit for unbudgeted expenditures by Council, recommending to the Constitution and Bylaws Committee that appropriate language be provided to reconstitute the Finance Committee as a committee of the House of Delegates rather than of Council, and authorizing the House Finance Committee to consider and approve expenditures recommended by Council which are in excess of a set limitation. This has been done with the Council's limit for unbudgeted expenditures set at 4 per cent of the annual Association budget. This recommendation will be considered at the current Session.

IV. **Research and Development Arm of MAG**

At its January 1975 meeting, Council voted to favor establishment of a Research and Development Arm for MAG, accepted a staff recommended budget for information only, and further recommended that the budget be referred to the Finance Committee for study and the proposition presented to the April Annual Session.

V. **Reapportionment of the Size of the House of Delegates**

This issue has been under study by the Committee on Reorganization and that Committee report will be forthcoming at this Session with recommendations.

VI. **Health Manpower (Physician) Study**

Council at its September 1974 meeting accomplished this directive, budgeting $4,400 for the study. A questionnaire has gone to all physicians in Georgia pertinent to the conduct of this study and at time of this writing the results of the replies are being received and analyzed. A report will be made to this Session.

VII. **Committee to Evaluate All Peer Review Mechanisms**

This Committee has been quite active under the chairmanship of Dr. John R. McCain. It has carried out its charge and will have a report for this 1975 Annual Session on its findings and recommendations.

VIII. **Committee on Physician's Assistants**

Such a Committee has been constituted, actively meeting, and has a report which will be considered by Reference Committee "C" at this Session. It has been suggested that this Committee should become a standing committee rather than have an *ad hoc* status.

IX. **Repeal PSRO**

1. MAY 1974
   At the Annual Session a clear position of total commitment to work for repeal of Section 249-F of P.L. 92-603 was established by MAG House of Delegates.

2. JUNE 1974
   In unexpected action, AMA House of Delegates established official AMA position to seek various amendments to statute but would proceed to implement. Vote 185 "For," 57 "Against." (MAG delegation to AMA unanimously voted "Against.")

3. JULY 1974
   In view of above, delegates to MAG House polled by mail. 186 inquiries; 119 replied. (a) 36 "For repeal." (b) 55 "For amendment." (c) 26—some combination of (a) and (b). (d) 3 "other opinions."

4. SEPTEMBER 1974
   Your Speaker reminded MAG Council of items (1), (2), and (3) and formally requested Council to give direction for continued MAG activity until next meeting of House of Delegates. Council voted to *"Encourage members to continue to support repeal but with no special expenditure of funds."*

5. JANUARY 1975
   Council rejected Executive Committee recommendation that 1975 House of Delegates be asked to have PSROG activated and designated as the PSRO for this State.

   Council instead directed that a MAG all-member poll be conducted on this question with results to be available for consideration by the 1975 House of Delegates. The PSRO Committee as charged has conducted the poll and will report results to the 1975 House. As of the time of this writing (February 25, 1975), a total of 2,164 replies have been received. 1,631 indicated "Yes," 389 responded "No" and 144 indicated "undecided." A final report of the results of this poll will be submitted to Reference Committee "B" for its consideration at this Session. A summary of these actions is also included in the Chairman of Council Report.

As the end approaches of my first year's service as the Speaker of the House, I more fully appreciate the responsibilities and duties of the Office and with greater humility approach the future.

I am indebted to the members of Council, including the Executive Committee, and especially to Staff for making it possible for me to achieve any degree of efficient service.

I remain sincerely appreciative of the opportunity to serve MAG in this capacity.

FIRST DISTRICT COUNCILOR

Albert M. Deal, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Ogeechee River				
Robert B. Stambuk				
Statesboro	23	21	22	21
Burke				
Charles G. Green				
Waynesboro	6	4	5	5
Emanuel				
H. W. Smith				
Swainsboro	5	4	6	6
Laurens				
Grady E. Longino				
Dublin	42	23	49	44
Screven				
James C. Freeman				
Sylvania	5	4	5	4
Southeast Georgia				
George Merritt				
Vidalia	13	10	11	10
	94	66	99	90

SECOND DISTRICT COUNCILOR

J. Daniel Bateman, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Colquitt				
Thomas R. Hester, Jr.				
Moultrie	19	17	16	14
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	13	9	14	7
Dougherty				
William Mayher, III				
Albany	88	69	81	63
Mitchell				
A. A. McNeill, Jr.				
Camilla	4	4	5	5
Southwest Georgia				
David Wetherby				
Ft. Gaines	10	7	10	6
Thomas Area				
James L. Story, Jr.				
Thomasville	55	46	53	44
Tift				
Sam Dixon				
Tifton	23	13	22	13
Worth				
R. T. Morgan				
Sylvester	5	3	4	3
	217	168	205	155

SIXTH DISTRICT COUNCILOR

James M. Skinner, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Clayton-Fayette				
S. T. Hartley				
College Park	19	15	25	23
Coweta				
Joel E. Mikell				
Newnan	20	15	24	20
Meriwether-Harris				
W. G. Chambless				
Hamilton	16	14	14	13
Spalding				
C. C. Releford				
Griffin	46	39	46	35
Troup				
C. P. Major				
LaGrange	41	33	36	30
Upson				
Pratoom Potitong				
Thomaston	18	16	19	16
	160	132	164	137

EIGHTH DISTRICT COUNCILOR

Robert E. Perry, Jr., M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Altamaha				
C. B. Kanavage				
Baxley	6	6	6	6
Ben Hill-Irwin				
C. Morgan Smith				
Fitzgerald	7	7	7	7
Coffee				
Tom Parker				
Douglas	9	9	13	11
Camden-Charlton				
Eduardo Oliveira				
St. Mary's	6	4	6	3
Glynn				
D. H. Manning				
Brunswick	59	49	57	50
Ocmulgee				
Frank Holder, Jr.				
Eastman	18	15	15	13
South Georgia				
Jose Campa				
Valdosta	72	52	66	56
Telfair				
D. B. McRae				
McRae	4	4	5	5
Ware				
George S. Heath				
Waycross	44	39	39	36

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Wayne Ollie O. McGahee, Jr. Jesup	9	7	9	6
	234	190	223	193

NINTH DISTRICT COUNCILOR

Paul T. Scoggins, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Barrow J. C. Souther Winder	8	7	9	8
Blue Ridge E. J. Fernandez Ellijay	5	4	3	3
Chattahoochee Rupert Bramblett Cumming	26	22	28	24
Cherokee-Pickens T. B. Alabanza Canton	17	15	22	18
Elbert Harold Campbell Elberton			8	4
Franklin-Hart Wesley W. Harris Royston	8	5	7	7
Habersham L. G. Hicks, Jr. Clarkesville	10	6	9	7
Hall John W. Garland, III Gainesville	74	66	80	66
Jackson-Banks S. A. Vickery Commerce	9	7	9	8
Rabun (disbanded)	4	4		
Stephens Robert W. Slate Toccoa	21	18	22	21
	182	154	197	166

TENTH DISTRICT COUNCILOR

Edwin W. Allen, Jr., M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Baldwin Perry Moore Milledgeville	56	28	51	30
Crawford W. Long James W. Maxwell Athens	86	70	86	73
Jefferson James W. Pilcher, Jr. Louisville	7	6	8	7
McDuffie William L. Vaughan Thomson	5	5	6	6
Newton-Rockdale Ragilio Bonau Covington	11	5	10	10
Oconee Valley M. L. Ferrell Sparta	12	11	10	10
Walton R. M. Tankesley Monroe	7	5	7	5
Washington John W. Traer Sandersville	9	3	8	2
Wilkes Sophia Bamford Washington	6	5	4	4
	199	138	190	144

COBB COUNTY MEDICAL SOCIETY COUNCILOR AND VICE COUNCILOR

Remer Y. Clark, M.D., Councilor, and Charles R. Underwood, M.D., Vice Councilor

The physicians of Cobb County are looking forward with great enthusiasm to the opening of our new 650 bed facility. This is scheduled by mid summer and is to include all the modern equipment to improve patient care in our area. We feel that the new Kannestone Hospital will be the hub of North Georgia as a medical center.

Cobb County Medical Society continues to salute several auxiliary activities that support the physicians in many ways. Not to mention their support would be unjust. Next week will be the annual Kennestone Ball, the proceeds primarily being in support of our Coronary Care Unit. We continue our annual joint meeting with the Cobb County Bar Society. Our appreciation is always more than can be expressed to our Woman's Auxiliary for their support through the Kennestone Gift Shop for equipment over the hospital in general, purchased from their profit. The Cobb County Symposium continues a liaison between the medical, clergy and bar societies.

Through the efforts of Dr. Dan Stephens our membership has increased to 236 members in the Cobb County Medical Society, 201 being members of MAG and 175 being members of AMA.

MEMBERSHIP

County and Secretary	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Cobb Robert Coggins Marietta	185	167	201	182

DEKALB COUNTY MEDICAL SOCIETY COUNCILOR

Luther M Vinton, Jr., M.D.

MEMBERSHIP

County and Secretary	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
DeKalb Stanley P. Aldridge Decatur	242	214	251	224

MEDICAL ASSOCIATION OF ATLANTA COUNCILOR

John T. Godwin, M.D.

The Councilors and/or alternate Councilors have attended all meetings of Council. They have actively participated in various committee functions and the activities of the Council. There are no specific recommendations at this time although the Councilors are aware and trying to keep abreast of the current problems facing medicine.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Medical Association of Atlanta R. Carter Davis, Jr. Atlanta	1,196	923	1,093	953
John T. Godwin Atlanta, Councilor				
Fleming L. Jolley Atlanta, Councilor				
J. Harold Harrison Atlanta, Councilor				

MUSCOGEE COUNTY MEDICAL SOCIETY COUNCILOR

Jack A. Raines, M.D.

Muscogee County Medical Society had a most successful year under the leadership of Dr. Floyd C. Jarrell. The monthly dinner meetings were well attended, and the programs were geared to the socio-economic aspects of medical practice, rather than the scientific.

The membership voted to ask the local interns and residents to join the society as active, dues paying members, to put them in the mainstream of medicine, and they also joined the Medical Association of Georgia.

We had 131 active AMA members, 157 MAG members and gained another delegate.

We were represented at each meeting of Council, and we tried to the best of our ability to bring the information back to the society members. However, since so much was discussed at Council this is not always an easy task, and we attempted to send a local Council Newsletter, but could not condense the information enough that we thought the members would read.

The society again sponsored their annual tennis tournament and this was enjoyed by all the tennis playing members of the society.

In March the members of the society met in a joint meeting with the members of the Columbus Lawyers Club, with the lawyers host in 1974. This will be hosted by the society this year and the program will be on Malpractice Insurance.

COMMITTEE ON PROFESSIONAL CONDUCT AND MEDICAL ETHICS

T. A. Sappington, M.D.

There have been about the usual number of complaints received by the committee this year. These have been referred back to the local medical societies for action, and most have been resolved.

The chairman did meet with one couple who were not satisfied with the action of the local medical society. The meeting lasted for several hours. A full committee meeting was not called. These people have carried their complaint on to the Medical Ethics Department of the AMA, and are still not satisfied. A full committee meeting would be of no benefit in resolving their complaint.

A full committee meeting has not been held during the year, but there probably should be at least one meeting held annually.

MAG staff under the direction of the chairman has been able to handle most of the complaints, therefore not justifying a full committee meeting. A summary of complaints and the action taken is sent to each committee member quarterly.

COMMITTEE ON EMERGENCY MEDICAL SERVICE

Carl Jelenko, III, M.D.

The Committee met in Atlanta, Georgia at the Headquarters of the Medical Association of Georgia on October 27, 1973, January 19, 1974, April 27, 1974, and July 27, 1974. Average attendance was 20, with +70 per cent of the Committee's membership present. The major concerns of the Committee during the report period comprised:

I. The Emergency Health Services Advisory Council (EHSAC). Five members of the Committee serve on this Council. The Council, which works through the Georgia Board of Human Resources, is advisory to that Board on all matters having to do with emergency health care. During the report period, a system of priority assessment of the counties for receipt of state and federal funding was developed. The system was incorporated in the base document submitted to DHEW in support of Georgia's application for EMHS funds. The system will use objective, readily obtainable data on each county allowing it to be priority listed by need and without prejudice to better-endowed counties. Additionally, emergency health systems (Regions) have been defined, and a method of priority-listing the systems and sub-assigning counties by priorities into these systems was developed. The Committee worked with the Council, the Georgia Hospital Association, and Georgia Regional Medical Programs to develop and obtain funding for an up-dated EMS communications sys-

tem for Georgia. Target date for complete saturation is January 1, 1975. Approximately 50 per cent of the system has been purchased and/or is in place as of this writing. Working with the State Department of Civil Defense, a system of identifying physicians as participants in mass casualty situations has been completed. The Department of Civil Defense has issued identification cards to the appropriate physician group. Also, the Committee worked with other agencies in an attempt to inform candidates for state office in November elections of the issues and needs obtaining in emergency health care in Georgia.

II. EMT/A Training
   a. Two areas were of concern to the Committee. Several ad hoc training programs were reviewed since state law requires that approval for programs be granted only if they are approved by the Committee. A system of making ad hoc programs obsolete—i.e., turning them into state certified programs—was developed.
   b. A program of training all EMT/A personnel and the use of radio communications; the use of intravenous fluids and drugs; of re-certifying and/or debriding the ranks was developed. Further, discussions are currently underway between the Committee and other appropriate agencies which will place the physician in a position to "sign off" on the acceptability of any candidate for state certification as an EMT/A.
   c. A Subcommittee on Education was created and met December 4, 1974 at the Ponce de Leon Avenue office of DHR. The Subcommittee comprises 17 members (7 from MAG) representing: MAG, EHSAC, DHR (EMS), Department of Education, Department of Highway Safety, EMT/A instructors, ACEP, MCG, Emory, OCD, MEMS, ambo providers, funeral directors, and the ACS Committee on Trauma. The group made significant progress in re-aligning EMT education and will meet in March 1975. Current members include: Carl Jelenko, III, M.D.: Robert E. Wells, M.D.; John Stone, M.D.; F. R. Freckleton, M.D.; Norman Berry, M.D.; Mr. Bo Pounds; Mr. Al Martin; Mr. Billy Clack; Mr. Carlton Fisher; Mr. Ralph Turner; William D. Bellam, Ph.D.; C. W. Sargent, M.D.; Mr. Phil Petty; Mr. Bob Mabry; Mr. Don Servais; and Capt. R. L. Fair.

III. Emergency Plan for the Hartsfield-Atlanta International Airport. Over the past four years, the Committee has worked diligently in an attempt to establish an appropriate emergency medical services program at the Atlanta International Airport—a facility that four hours daily is the busiest in the world. Seed funds were located within the Georgia Regional Medical Programs to support personnel and equipment; and the Committee was able to negotiate with the Airport Authority to accept this aid and to continue the funding and support of the program after the initial infusion of GRMP dollars. Equipment has been ordered and/or obtained; a medical care group has been identified; and this project appears to be on a solid foundation currently.

IV. In conjunction with the Georgia Chapter of ACEP, the MAG Committee on Emergency Medical Services sponsored a three day practicum/workshop on Basic Emergency Management at the Atlanta Internationale Hotel December 2-3-4, 1974. Chief topics of discussion included shock, EKG interpretation. Methods included both didactic/seminar presentations and integrated workshops. The audience was primarily physicians devoting a major commitment to emergency care.
   a. The last meeting of the Committee was February 23, 1975. The Committee meets at approximately 12 week intervals.

V. Activities
   a.,b. Sponsored and/or co-sponsored by the Committee: See number 4 above.
   c. Future Activities: Three or four areas are subjects of continuing work. These include continued participation in and cooperation with the Emergency Health Services Advisory Council in the development of a regionalized system of EMS in Georgia. Work has begun in developing a program for recertification and reexamining Emergency Medical Technicians, and decertification of same. Progress of the program at the Hartsfield-Atlanta International Airport will require monitoring. Further, the Committee will work with other agencies in an attempt to assure that adequate budget is appropriate for Emergency Health Services needs in the coming Fiscal Year.

Comments

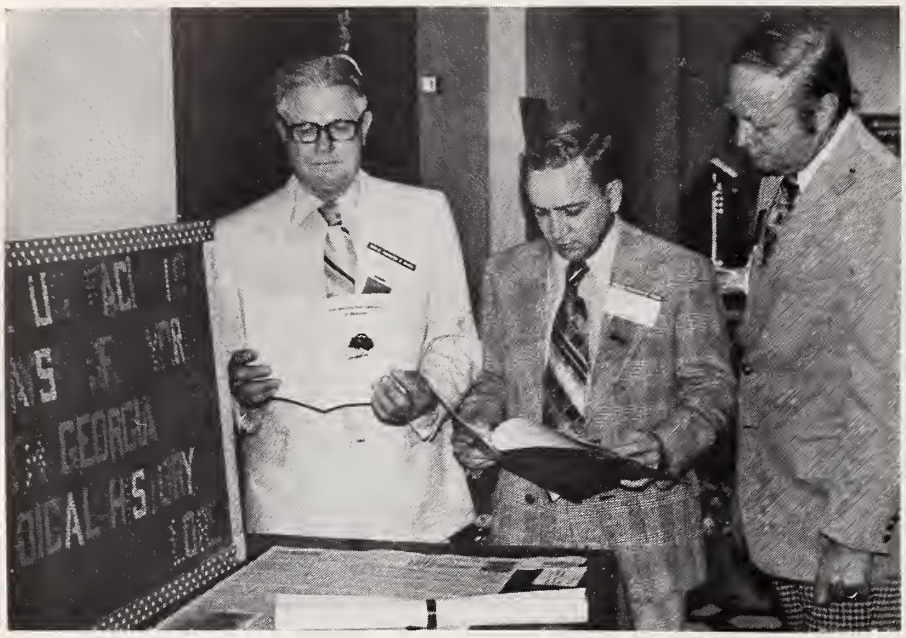
The Committee is satisfied that substantial progress is continuing to be made in Georgia with regard to EMS activities. A major lack is availability of funds with which to implement a variety of programs which are, administratively and on a planning level, at least, in place. The Committee also appreciates the need for input and coordination of efforts by many of the smaller, more rural counties. Efforts at improving the dialogue between county government and the Committee; and between the physicians of various of the smaller counties and the Committee are in progress, although current yield is not satisfactory. There are no recommendations from the Committee to the Council.

COMMITTEE ON CANCER

Hoke Wammock, M.D.

The Committee on Cancer has had a particularly busy year, much of its activities centered around Georgia's cancer control program. The Committee assisted the Georgia Cancer Management Network in the development of a grant proposal to establish a Community Based Cancer Control Program. If funded by the National Cancer Institute, the program would:

I. Develop the administrative capacity of a community to provide leadership in cancer control, and coordinate and wisely use community resources, as well as NCI and other federal resources, in developing and maintaining a comprehensive cancer control effort;
II. Mobilize the resources (i.e., people, facilities,



An impressive room filled with Auxiliary exhibits and displays on projects is viewed by Drs. John M. Martin of Augusta, Jimmy Asbell of Macon and William D. Logan of Atlanta.

funds) of the community so that a comprehensive cancer control program can be initiated and eventually become self-sustaining;

III. Plan and put into effect, a comprehensive cancer control scheme for the community, utilizing all tested and acceptable intervention procedures and methods in a program especially designed for the community and based on known epidemiologic characteristics of the disease, and the demographic and socio-economic characteristics of the community;

IV. Establish an evaluation scheme whereby the community organization and NCI can monitor the progress of the program, and assess the impact of intervention activities against selected cancers within the community.

One of the goals of the National Cancer Institute is to provide assistance to practicing physicians throughout the country who are working in private practice or in group practices, so that they can have available the most accurate and up-to-date information on cancer diagnosis and treatment to guide them in their decisions on the management or referral of cancer patients. Since the great majority of cancer patients are first seen by physicians who are not practicing in Comprehensive Cancer Centers nor in academic institutions, and since the decisions made at those first encounters are so critical for the patients' survival, we believe that efforts devoted to informing practicing physicians of new developments in diagnosis and treatment for the many different types of cancer, of the backup resources necessary for optimum management, and where further consultation can be obtained would be one of the most valuable contributions the NCI could make under its legislative mandate to develop a program in cancer control.

The Georgia Cancer Management Network had been created by the Committee on Cancer, the Georgia Regional Medical Program, the Georgia Division of the American Cancer Society, and Liaison Fellows of the Georgia Chapter of the American College of Surgeons, the Georgia Department of Human Resources, and the two medical schools in order to coordinate these and other cancer control activities. During this year, the Network applied for—and received—a grant for a "Prototype Network Demonstration Project in Breast Cancer." An application for a "Prototype Comprehensive Network Demonstration Project for Head and Neck Cancer" was submitted, but not funded.

It was generally felt by the Committee on Cancer that the $400,000 operating budget of Georgia's State-Aid Cancer Control Program was inadequate. The following position was taken by the Committee on Cancer with regard to that program:

I. That cancer be made a reportable disease in Georgia, and

II. That monies be added to the Cancer Control Unit, Adult Health Section of the Department of Human Resources in order to:
   a. Make eligibility of State-Aid cancer clinic patients similar to Kidney Disease Control eligibility, and to publicize the program and add 4,000 new patients, pay 100 per cent of hospital and outpatient costs (excluding professional fees), and add a cancer specialist consultant part time to the Cancer Control Unit.
   b. Provide a full-time Public Health Nurse and clerican support to each of 16 Public Health Districts for cancer detection, screening, and education in Public Health clinics,
   c. Support a statewide SEER-type cancer registry,
   d. To provide (with approval of the clinic chief) terminal care for certain hardship cases in chronic disease facilities primarily, and
   e. To make available $5 million in low-interest, long-term loans funds to non-profit community hospitals for purchase of cancer therapy equipment—such as radiotherapy items.

The Committee on Cancer oversees the operation of the Georgia Cancer Registry which MAG operates under contract with the Georgia Department of Human Resources. The Registry now serves 17 hospitals, and employs a staff of registry consultants who assist participating hospitals in maintaining and upgrading their cancer registries. Though $90,000 was available for the nine-month operating period of the Georgia Cancer Registry this year, it appears that only $60,000 will be available for the entire 12-month period beginning July

1, 1975. Until supplemental funding can be secured from the Georgia Department of Human Resources, the operations of the Georgia Cancer Registry will be reduced in scale. Related to the Registry is the application submitted this year to the National Cancer Institute that—if funded—would permit the development and operation of a Surveillance, Epidemiology, and End Results (SEER) data system to complement the Georgia Cancer Registry operation in the Metropolitan Atlanta area. This application is still pending.

In reviewing our activities of the last year, I wish to express my appreciation to members of the Committee on Cancer for their time and untiring efforts, as well as to Executive Committee and Council for their advice and cooperation.

COMMITTEE ON LEGISLATION—NATIONAL

Harrison L. Rogers, Jr., M.D.

During the 93rd Congress more than 2,000 bills were introduced in the House and Senate which were of interest to physicians. Obviously, there are too many to consider all of these bills, but several were of extreme importance to the Medical Association of Georgia, and your Committee on National Legislation kept in contact with our Congressmen and Senators by phone, telegram and letter. The following is a discussion of some of the legislation which most concerned MAG.

National Health Planning and Development and Health Facilities Assistance Act of 1974

This bill passed Congress on the last day of the 1974 session and was signed by President Ford January 3. The measure replaces the Comprehensive Health Planning Program and the Regional Medical Programs. It would further modify and extend the Hill-Burton hospital construction program. States are required to adopt certificate-of-need legislation governing the development of new institutional health services proposed to be offered or developed within the State. The State Agency would also review the necessity of certain institutional services and facilities in order to determine whether costs were reimbursable under the Medicare program.

A system of health systems agencies would be developed pursuant to which the country would be divided into regions equivalent to PSRO areas, existing local planning areas and state planning and administrative areas. The local and state agencies would develop and implement both long-range and short-range health plans under national guidelines developed by the Secretary of HEW. These guidelines would include standards respecting the appropriate supply, distribution and organization of health resources as well as a statement of national health planning goals expressed in quantitative terms. The national guidelines would include . . . the development of multi-institutional systems, coordination and consolidation of institutional health services (including obstetrics, pediatrics, emergency medical, intensive coronary care and radiation therapy services) . . . the development of medical group practices, health maintenance organizations and other organized systems for the provision of health care . . . the training and increased utilization of physician assistants, especially nurse clinicians . . . the development of multi-institutional arrangements for the sharing of support services necessary to all health services institutions . . . and the adoption of uniform cost accounting, reimbursement and utilization reporting systems.

The bill further authorized grants for demonstration projects with respect to the regulation of rates for the provision of health care. The Secretary would be empowered to enter into agreements with not more than six states which have adopted rate regulation legislation or have indicated an intent to establish such procedures.

The Hill-Burton program, as extended, authorizes assistance for the modernization of medical facilities, the construction of new outpatient medical facilities, construction of facilities in areas which have experienced recent population growth and for the conversion of existing medical facilities for the provision of new health services. Not less than 25 per cent of any state's allotment would be used for the construction of outpatient facilities serving medically underserved populations.

Health Manpower Bill

This bill amends the Public Health Service Act to revise and extend the programs of assistance under Title VII for training in the health and allied health professions, to revise the National Corps scholarships, and to provide financial assistance in the construction of teaching facilities. The bill continues present authority for capitation assistance by becoming a member of the National Health Service Corps and practicing in a medically underserved area, or as a member of the Indian Health Service, or in accordance with an agreement to serve in a shortage area. The bill would also establish a mechanism for controlling the numbers and kinds of residency programs available to medical students, limiting the total number of graduates from U.S. schools of medicine in the preceding year. This bill (S. 3585) did not pass during the 1974 session but has been reintroduced this year as H.R. 2956.

Malpractice Liability of Physicans

The American Medical Association urged the Administration to explore the feasibility of legislation dealing with the malpractice liability of physicians who treat beneficiaries of federal programs.

AMA President Malcolm C. Todd, M.D., stated, "What is needed is a swift system for paying deserving claims so that justice can be prompt. For both the physician accused of malpractice, who bears a severe emotional burden, and the patient who becomes an unfortunate plaintiff, justice delayed is justice denied." Dr. Todd noted that in 1975, as much as 50 per cent of the cost of health care may be provided through government programs. At present, it is estimated that after all costs of the tort system are met—fees to defense and plaintiff's attorneys and witnesses, costs of investigation, and insurance underwriting—plaintiffs actually receive a net of only $1 out of every $6 paid in premiums for liability insurance. He pointed out that government health care programs now contribute a major part of the cost of a system which provides claimants with only about 16 cents out of every dollar paid for malpractice insurance.

Dr. Todd continued, "Any payments or awards made to claimants arising out of medical accidents should exclude medical costs which, in fact, were actually paid

for by Medicare, Medicaid, etc. Under existing law, a successful malpractice claimant can recover for medical and hospital costs that have been paid or that will be paid in the future by Medicare, Medicaid, etc. Such windfall payments which the government pays for directly or indirectly should cease."

National Health Insurance

The NHI bills will have to be reintroduced this year. This issue is of major concern to all physicians. Many high officials think the economic situation the country is now experiencing will be a deterrent to NHI.

Senator Kennedy, among others, will try to pass a version of NHI during the 1975 session.

Annual Congressional Luncheon

As in the past, a group of Georgia physicians, one from each Congressional District, had lunch with Georgia's Senators and Representatives on March 20 in Washington. Our Congressional delegation has expressed how much they enjoy this affair in that it gives them a closer look at the viewpoints of the Georgia physician and MAG.

During the 1975 session of Congress your Committee on National Legislation plans to send a member of the MAG staff or one of its members to Washington every month. We feel this not only will keep the MAG membership informed on national legislation, but will also create better communication and responsiveness on medical issues from Georgia's 10 Representatives and two Senators.

COMMITTEE ON MENTAL HEALTH

W. S. Davis, M.D.

The Mental Health Committee had as its chief project for this past year the task of hosting the Southeastern Regional Mental Health Conference which was held under the co-sponsorship of the MAG at the Marriott Motor Hotel, in April. The theme of the conference focused on current trends in mental health care and the program was extremely well presented by a number of outstanding leaders in the field of mental health.

Representatives from within as well as outside the Southeast were in attendance and the program was well received by those present. The committee felt the meeting was quite successful.

In addition, the Mental Health Committee considered various legislative proposals affecting mental health which came before the legislature. This was a rather lean year in this regard since much effort was expended in the in-fighting between the Governor's office, the Department of Human Resources and various legislators over the organization and functions of the Division of Mental Health. The chief proposal considered was the Uniform Alcoholism Act which the committee unanimously endorsed.

COMMITTEE ON OCCUPATIONAL HEALTH

Tom Howell, M.D.

The Occupational Health Committee had its annual luncheon meeting April 25, 1974. Judge Albert D. Crenshaw was the guest speaker and he reviewed the changes in Workmen's Compensation that had been passed by the preceding State Legislature. Discussion was particularly directed towards the new State Law regarding payment of Workmen's Compensation for partial loss of hearing.

Members of the Occupational Health Committee are presently serving on:

1. Medical Advisory Committee to the State Board of Workmen's Compensation
2. Medical Committee on Occupational Diseases
3. State Rehabilitation Committee

Chairman of the Occupational Health Committee is a member of a group designated to assist in bringing Georgia's Workmen's Compensation Laws up to the National Standard.

Anticipated changes in Workmen's Compensation Laws provided for information:

1. Instead of employee or insurance company designating the treating physician, a panel of three physicians will be offered. This is the first step towards "freedom of choice" of physicians for Workmen's Compensation patients.
2. Increase in the average weekly benefits to two-thirds of the average weekly State wage. (This will mean an increase in the weekly benefits to approximately $95.00 per week.)
3. Payments of benefits will begin on the third day after injury rather than at the end of one week as is now practiced.
4. Medical benefits will be unlimited and payment for disability will probably be "lifetime."
5. There will be payment for prosthetic devices sustaining trauma on the job (false teeth, glasses, artificial members, etc.)

COMMITTEE ON PRIVATE PRACTICE

W. Daniel Jordan, M.D.

The Private Practice Committee met in August 1974, pursuant to a resolution adopted by the House of Delegates concerning medical information supplied to Credit Bureaus. At this meeting considerable discussion was held with representatives from the Retail Credit Company. They described the activities of the underwriting division of their company. This was reported as having a two-fold purpose, first to assist the applicants in obtaining insurance policies and, secondly, to help the physician by reducing the paper work involved. The representatives also reported that each prospective policyholder is informed that there will be a check of his medical history and that he signs an authorization for the release of this information. The Retail Credit Company retains only a flow sheet indicating that the data has been gathered and that it has been forwarded to the requesting carrier. Retail Credit Company was emphatic in their statement that they did not retain any of the medical information provided to them by the physicians involved.

Following this meeting, it was recommended to the Executive Committee of Council that an all-member mailing be carried out in hopes of explaining to the MAG membership the position of Retail Credit Company in gathering medical information and sending them examples of the authorization for release of medical information. This mailing was subsequently accomplished.

Further items considered at this meeting consisted

of an explanation of the CHEC program from representatives of the Georgia Medical Care Foundation as well as an examination of the lengths of stay for various diagnoses associated with hospital admissions. This information was anticipated to be used in the application of the CHEC program throughout the state.

Future subject material was also discussed, and it was felt that there were two very specific issues that should be discussed at future meetings. These included the question of physician liability under Section 213 of Public Law 92-603 and the possibility of mechanisms of closed hospital medical staffs with their impact on the private practice of medicine.

RURAL HEALTH COMMITTEE

Irving D. Hellenga, M.D.

April 1974 marked the visit of the Chairman to AMA's 27th National Rural Health Conference at the Detroit Hilton. An emphasis at the Conference was on the contribution to rural health care of group practice clinics, nurse professionals, and HMOs. Emphasis on the provision of care by the private sector was also noted.

Our Tenth Annual State Rural Health Conference was held in Macon August 28 and 29, 1974. Our Committee, in cooperation with the Georgia Farm Bureau and the Extension Service of the University, invited Dr. Joseph Wilber to talk on hypertension screening through the Department of Human Resources. Also invited was Mrs. Dorothy Winn of the Department of Human Resources' Health Access Station in Rochelle to tell the Conference about her facility. Professor Zack Acree, Dr. Nan Preas, and Dr. John Rooney gave reports on their work with school child health, nutrition in Georgia, and intensive treatment of alcoholism, respectively. The Georgia 4-H winners in health and safety gave presentations.

Members of the Committee visited three MAG district meetings to present the "Partnership in Health" program of the Department of Human Resources, with good response.

The Chairman participated in two workshops, at the National Rural Health Conference in Roanoke, Virginia, on March 19, 1975.

The Eleventh Annual Rural Health Conference is scheduled for the Medical Center of Central Georgia, Macon, August 27 and 28, 1975, with the Georgia Farm Bureau and the Extension Service, Department of Agriculture as the co-sponsoring organizations. The theme is to be: "Where Do We Go for What in Rural Health Care?" Members of co-sponsoring organizations will be present, and a large attendance by physicians is encouraged.

COMMITTEE ON SCHOOL CHILD HEALTH

Fred L. Allman, Jr., M.D.

The function of the School Child Health Committee of the Medical Association of Georgia during the past year as in previous years has been to stimulate cooperation by individual physicians and the School Child Health program, to keep the profession informed of the school health program, and to report to the profession on the progress. The School Child Health Committee has continued to try to improve its relationship with the Dental Association, the public school system, the Health Department, parents groups, Georgia High School Coaches Association, and other appropriate organizations. Specifically, the committee has been involved in the following activities during the past year.

I. **Follow-up on Existing Projects**

a. Smoking and Health. The teacher resource kits which were placed in the schools in 1967 in cooperation with the State Department of Education and the Georgia Heart Association, the Georgia Tubercular Association, the Georgia Cancer Society, and the State Health Department have continued to be utilized in many schools throughout the state and have been used as a model for other states.

b. Postgraduate Course. The Medical Association of Georgia, through the Committee on the Medical Aspects of Sports and the School Child Health Committee, again sponsored a postgraduate course on the medical aspects of sports. This program was held in conjunction with the Georgia High School Coaches Clinic, in conjunction with the Georgia High School All-Star Football and Basketball Games. The speaker sponsored by the Medical Association of Georgia was Dr. George Ford, orthopaedic surgeon from Florida, who talked on back problems in athletes. Again, a highlight of the meeting was a luncheon which was co-sponsored by the Health Department under the supervision of Mrs. Mary Helen Goodloe and the Coca-Cola Company. This was a nutrition luncheon which has been a part of the medical aspects of the sports program for the past six years. More than 100 coaches and physicians attended the luncheon and participated in an informal discussion.

c. News Release. A news release was sent to all of the news media throughout the state in August concerning the safe methods of conducting athletic practices and events in hot, humid weather.

d. Pre-school Screening of Vision and Hearing. The committee, while no longer actively involved in this endeavor, has continued to cooperate with the Georgia Society of Orolaryngology and the Georgia Society of Ophthalmology, as well as the Georgia Society for the Prevention of Blindness in helping to establish pre-school screening for vision and hearing in the counties throughout the state.

II. **Old Projects Not Yet Completed**

a. Certification of Coaches. The certification of coaches with minimum standards of instruction in important subjects, such as first aid and other preventive measures, continues to be an important item on our agenda of things that must be accomplished. Several discussions have been held toward this end and it is hopeful that through the cooperation of the existing educational institutions of higher learning within the state this will soon become a reality.

b. New Comprehensive Form for Pre-participation Physical Evaluation of Athletes. Definite forms have been prepared in the state of New York and has been very successful in utilizing this as part of the pre-participation physical evaluation of candidates for sports activities. It is hopeful that within the year information pertaining to the method of determination of the level of maturity will be in the hands of Georgia doctors so that they might utilize this in their evaluation.

III. **New Business**

During the year the chairman of the committee concurred with other members of the Medical Association of Georgia who felt that the interest of the athlete and the school child could best be served by having two separate committees—one on school child health and one on the medical aspects of sports. This was presented to the executive committee for their consideration and hopeful implementation.

Second, the chairman has been in touch with Lillian P. Warnick, Chief, Child Health Unit of the Georgia Department of Human Resources, and it is my feeling after my talk with Dr. Warnick that the interests of both the Committee on the Medical Aspects of Sports and on School Child Health could best be served by having a liaison representative of the Department of Human Resources available to these committees. Possibilities for this liaison relationship would be Dr. William Mason, consultant to the Child Health Unit; Dr. Jules Terry, Director of the Family Health Division of Physical Health, and possibly Miss Jeannette Dohnal, the consultant nurse for school-aged children programs. In addition, Dr. Warnick has offered her services to either or both of these committees.

In concluding, the committee would like to encourage each member of the Medical Association of Georgia to help develop the integrated relationship of health and education. There can be no question that one needs to be educated in order to develop and protect one's health and one needs abundant health to make full use of one's education. It is a reciprocal and actual relationship that deserves the attention of every physician in Georgia.

INTERSPECIALTY COUNCIL

James K. Van Buren, M.D.

At its September 1974, meeting the Interspecialty Council endorsed an MAG proposal to hold a fall Scientific Session in 1975 which would provide a forum for the various specialty societies to present their own scientific programs. The Interspecialty Council will continue to work with MAG on the planning of the 1975 Scientific Session.

THE GEORGIA REGIONAL MEDICAL PROGRAM

J. Gordon Barrow, M.D.

As most of you are aware, Congress has terminated the Regional Medical Program with passage of the new health planning law. During the eight years of its existence, the Georgia Regional Medical Program has brought more than $17 million into the state in federal funds to assist in the improvement of medical services and facilities throughout the state. Doctors from all over the state have given generously of their time and talents in the many hundreds of Task Force and Regional Advisory Group meetings to set the policies of this program, and as Project Directors for the local projects throughout the state. As a result, we have had one of the better programs in the country.

Most of the current activities will terminate about August 1975, although a few may continue until December 1975. The staff will remain in the MAG offices until December 1975 to complete the final reports and to close out the operation.

I wish personally to express my appreciation to the Medical Association of Georgia and to its hundreds of members who have worked to make this a good program. I especially want to express my appreciation to Doctors J. W. Chambers, G. H. Alexander, M. D. Adair, and Luther M. Vinton, all of whom have served for a period of time as Grantee Liaison between the Georgia Regional Medical Program and the Medical Association of Georgia.

THE *JOURNAL*

Edgar Woody, Jr., M.D., Editor

COSTS AND REVENUES

The volume of our advertising and increasing costs of producing the *Journal* are of constant concern and study. While paper costs have gone up several times in the past year, we actually have been able to spend slightly less in producing the publication. This is because the number of pages of advertising has been down several months, the volume of editorial material consequently has been reduced and smaller journals sometimes produced. At the moment advertising appears to be on a healthy upswing.

The State Medical Journal Advertising Bureau, a Chicago-based agency soliciting and arranging national advertising for most of the state medical journals, continues to work hard for us. They have suggested and planned many cost saving measures and campaigns to attract advertisers. Included in this effort is the use of two readership surveys of 1974 which show the state journals to place above national publications such as *Medical Economics, JAMA* and *Physician Management* in ad page exposure and "scan scores."

CONTENT

The *Journal* continues to strive to accurately report the activities of the Association and its individual members and to keep the medical community updated on developments in areas such as PSRO, HMOs and medical legislation. We have covered activities of related public service and professional associations and the AMA. The increasing importance of continuing medical education is reflected in the number of articles and lists of opportunities published.

CREDITS

The Publications Committee, contributing editors and headquarters staff members are to be thanked for



James M. Sammons, M.D., executive vice president of the AMA, congratulates J. W. Chamblers, M.D. (L) of LaGrange and John S. Atwater, M.D. (R) of Atlanta on their long service to the AMA as delegates. Both men chose not to seek reelection. Dr. Sammons stressed in his address the need for more medical schools, larger classes, and greater enrollment if organized medicine is going to respond reasonably to the problem of access to and utilization of health care in this country.

their ideas, contributions and encouragement. They have been called upon at every phase of producing the *Journal*. Outgoing President J. Rhodes Haverty is to be commended on the versatile style and thought-provoking content of his letters. J. G. McDaniel is applauded for his efforts on the feature page, "I've told this before," and has been joined by a new contributor, Carl Jelenko, M.D. A valuable feature of the *Journal* is the specialty pages for which appreciation is given to I. W. Joines, II, M.D., for the Heart Page; Mrs. Shirley Preston of the American Cancer Society, Georgia Division for the Cancer Page; and Winston Huff, legal counsel to MAG for the Legal Page. Bob Hamill has continued to produce excellent covers for the *Journal*.

Speaker Buchanan then called on the President to introduce Dr. James H. Sammons, Executive Vice President of the American Medical Association. Dr. Sammons addressed the House on the state of the AMA.

The Speaker proceeded to new business calling for the introduction of resolutions and requested that the "Resolved" portion only be read to the House. The following resolutions were then presented:

Resolution 1-75: Medicaid Payments—Reference Committee A

Resolution 2-75: Professional Liability—Reference Committee D

Resolution 3-75: Professional Standards Review Organization—Reference Committee B

Resolution 4-75: Creation of Committee on Government Health Programs—Reference Committee D

Resolution 5-75: Implementation of PSRO in Georgia —Reference Committee B

Resolution 6-75: Certification Responsibility—Withdrawn

Resolution 7-75: Adequate Training for Geriatric Medicine—Reference Committee C

Resolution 8-75: MAG Support of American Trauma Society—Reference Committee C

Resolution 9-75: Fiscal Audit—Reference Committee B

Resolution 10-75: Medicaid Payments—Reference Committee A

Resolution 11-75: Evaluation of MAG priorities—Reference Committee F

Resolution 12-75: Implementation of PSRO—Reference Committee B

Resolution 13-75; Repeal of the PSRO Law—Reference Committee F

Resolution 14-75: PSRO—Reference Committee B

Resolution 15-75: Central State Hospital Study—Reference Committee A

The Speaker then recognized President Haverty for the purpose of presenting two special resolutions to Dr. J. W. Chambers and Dr. John S. Atwater for their service to MAG over the past several years. Dr. Haverty read the two resolutions, presented them to Dr. Chambers and Dr. Atwater and the House adopted the resolutions by unanimous consent.

Following Dr. Sammons' address, the Speaker announced that Reference Committees would meet at 1:30 p.m. He expressed his appreciation for the services of those members who served on Tellers and Credentials Committees and announced that the First Session of the House of Delegates would stand recessed at 1:15 p.m.

Georgia Medical Political Action Committee Brunch

Saturday, April 19, 1975

THE SECOND ANNUAL GAMPAC BRUNCH was held in the Ballroom at the Fairmont Colony Square Hotel, Atlanta, Georgia, at 9:00 a.m., on Saturday, April 19, 1975.

The invocation was given by Mrs. Mary Wells, wife of Dr. David A. Wells of Dalton, MAG President-Elect.

J. Daniel Bateman, M.D., Albany, Chairman of the Georgia Medical Political Action Committee called for a round of applause for the 530th Air Force Band of the Georgia Air National Guard, headed by Major Gordon Moore. Dr. Bateman then proceeded to introduce the head table as follows: Rusty Kidd, MAG Director of Legislative Activities; Mrs. J. Rhodes Haverty; David A. Wells, M.D., MAG President-Elect; Mrs. George D. Busbee; Mr. James M. Moffett, MAG Executive Director; Mrs. David A. Wells; J. Rhodes Haverty, M.D., MAG President; Mrs. Mary Ellen Bateman, Co-Chairman of GaMPAC; and the Honorable George D. Busbee, Governor of the State of Georgia.

Dr. Bateman recognized other distinguished guests in the room as follows: Mrs. Linda Harrison, President of the MAG Woman's Auxiliary; Mrs. Frances Astin, President-Elect of the MAG Woman's Auxiliary; Mrs. Betty Andrews, Auxiliary State Legislative Chairman; James A. Kaufmann, M.D., Chairman of State Legislative Committee; and Harrison L. Rogers, Chairman of the National Legislative Committee.

The newly appointed (and reappointed) GaMPAC Board of Directors was presented by Dr. Bateman. The members are: First District Chairman—Leon Curry, Metter; Second District Chairman—Robert P. Wight, Tifton; Third District Chairman—James Sullivan, Columbus; Fourth District Chairman—James Joiner, Decatur; Fifth District Chairman—William C. Collins, Atlanta; Sixth District Chairman—Curtis Batchelor, Bremen; Seventh District Chairman—Lee H. Battle, Rome; Eighth District Chairman—Jack Menendez, Macon; Ninth District Chairman—Billy Hardman, Gainesville; and Tenth District Chairman—J. Kenneth McDonald, Augusta. Other members of the GaMPAC Executive Committee were presented. They are Ollie O. McGahee of Jesup, George Green of Sparta and Earnest C. Atkins of Decatur.

Dr. Bateman then recognized past GaMPAC Board members for their dedication and support of GaMPAC and asked them to stand and be recognized. He then introduced Miss Lynn Pearson, GaMPAC Secretary, and expressed the committee's appreciation for her work.



Gov. and Mrs. George Busbee find their places at the head table as guests of honor for the GaMPAC Brunch.

Dr. Bateman announced the recipients of the GaMPAC awards as follows: The first award to the county medical society with 12 or fewer members reporting the highest percentage increase in GaMPAC membership was given to the Blue Ridge Medical Society. The next award to the county medical society with 13 to 25 members reporting the highest percentage increase in GaMPAC membership was given to the Colquitt County Medical Society. The percentage membership award for those county societies of 26 members and over was won by the Ware County Medical Society. The award to the district medical society reporting the highest percentage increase in GaMPAC membership was won by the Ninth District. The award for the highest percentage increase in sustaining memberships ($99+) was given to the DeKalb County Medical Society.

Following the presentation of awards, Dr. Bateman introduced Governor George Busbee, who delivered an address to the meeting.

At the conclusion of Governor Busbee's address, Dr. Bateman announced that an MAG General Session would follow in approximately 10 minutes, whereupon he adjourned the GaMPAC meeting at 11:05 a.m.

MAG Second General Session

1975 Annual Session Business Meeting
Saturday, April 19, 1975

THE SECOND GENERAL SESSION of the 1975 Annual Session Business Meeting of the Medical Association of Georgia was called to order on Saturday, April 19, 1975, by J. Rhodes Haverty, M.D., MAG President, at 11:15 a.m. in the Ballroom of the Fairmont Colony Square Hotel, Atlanta, Georgia.

AMA-ERF

President Haverty presented to the two medical schools in Georgia unrestricted grant monies in the form of an AMA-ERF check raised by contributions from the physicians and Woman's Auxiliary during the previous year. Dr. Haverty presented the checks as follows:

To Dr. Fleming L. Jolley, accepting on behalf of Dean Arthur Richardson of the Emory University School of Medicine, a check in the amount of $5,940.97.

To John M. Martin, M.D., on behalf of Dr. Curtis Carter, Dean of the Medical College of Georgia, a check in the amount of $4,198.71.

Fifty Year Pins and Certificates

Luther Thomas, Jr., M.D., was asked to present the 50-Year Certificates and Pins to those members who were graduated from medical school and licensed to practice 50 years ago. They were:

Evert A. Bancker, Atlanta; Clark H. Bryant, Comer; Verlin L. Bryant, Wadley; Daniel L. Burns, Valdosta; John Bush, Columbus; John R. Evans, Stone Mountain; Major F. Fowler, Atlanta; Thomas B. Gay, Atlanta; William A. Kelley, Atlanta; Ruskin King, Savannah; Harold P. McDonald, Atlanta; Hugh G. Mosley (deceased), Atlanta; Carl P. Savage, Montezuma; Bruce Threatte, Columbus; Richard B. Weeks, St. Simon's Island; R. Hugh Wood, Atlanta.

Life Membership

W. Dan Jordan, M.D., was called on to present special gold membership cards to MAG Life Members as follows:

Oliver Arteaga, Atlanta; Rudolph Bell, Thomasville; H. J. Bickerstaff, Columbus; W. C. Boswell, Thomasville; Leslie Buckner, Leesburg; Don Cathcart, Atlanta; Grady N. Coker, Canton; Murphy K. Cureton, LaFayette; John I. Hall, Macon; Alton V. Hallum, Sr., Atlanta; James P. Hanner, Atlanta; G. H. Johnson, Jr.; Savannah; S. B. Kitchens, LaFayette; Lawrence P. Matthews, Atlanta; J. R. S. Mays, Macon; Charles E. McArthur, Cordele; Willis T. McCurdy, Stone Mountain; W. A. Mendenhall, Decatur; Charles Rieser, Atlanta; Samuel F. Rosen, Savannah Beach; W. Pat Smith, Decatur; John L. Stapleton, Columbus; Frank Vinson, Fort Valley.

Certificates of Appreciation

President Haverty called on Earnest C. Atkins, M.D., Secretary, to present the Certificates of Appreciation to individuals deserving of special recognition for their contribution to medicine as follows:

J. Rhodes Haverty, M.D., as MAG President 1974-





Champagne leads off the GaMPAC Brunch, now a tradition in its second year. An Auxiliary helper pours refills for (L-R) Rusty Kidd, MAG legislative representative, F. G. Eldridge of Valdosta, President-Elect Fleming Jolley of Atlanta and C. Emory Bohler of Brooklet, past president. Robert Wells of Atlanta leads a line of delegates and their wives at the buffet table.

75; Luther M. Thomas, M.D., as MAG First Vice President 1974-75; Edgar Woody, M.D., as Editor, the *Journal of the Medical Association of Georgia* 1954-1974; Braswell E. Collins, M.D., as Bibb County Medical Society Council 1965-74; J. W. Chambers, M.D., as AMA delegate 1960-75; Mrs. George I. Harrison as President, Woman's Auxiliary to the Medical Association of Georgia 1974-75; Irving D. Hellenga, M.D., as Chairman, Committee on Rural Health 1970-75; Thomas E. Whitesides, M.D., Chairman, Interspecialty Council 1972-74; C. Emory Bohler, M.D., as President, Georgia Medical Care Foundation 1974-75; L. C. Buchanan, M.D., as member, Georgia Medical Care Foundation Board of Directors 1970-75, as Vice President, Georgia Medical Care Foundation 1970-74, as Treasurer, Georgia Medical Care Foundation 1974-75, as DeKalb County Medical Society Councilor 1971-75; Donald R. Rooney, M.D., as member, Georgia Medical Care Foundation Board of Directors 1973-74; John S. Atwater, M.D., as AMA delegate 1965-75; Corbett H. Turner, M.D., as member, State Board of Human Resources 1972-75; M. C. Adair, M.D., as member, Georgia Medical Care Foundation Board of Directors 1973-74; Charles B. Watkins, M.D., as Chairman, Ad Hoc Committee on Foreign Medical Graduates 1974-75; Gustav D. Anderson as Executive Secretary, Georgia Medical Care Foundation 1972-75; Remer Y. Clark, M.D., as Cobb County Vice Councilor and Councilor 1968-75; Lewis A. Hazouri, M.D., as Muscogee County Vice Councilor 1971-75; Robert P. Wight, M.D., as Chairman, Committee on Communications 1972-75; Paul T. Scoggins, M.D., as Ninth District Vice Councilor 1958-68 and Ninth District Councilor 1968-75.

Family Physician of the Year Award

Each year MAG presents an award to the Family Physician of the Year and calls upon the Board of Directors of the Georgia Academy of Family Physicians to select the recipient of this award.

Dr. Haverty then called upon Dr. A. J. Yates, substituting for Dr. James Dismukes, President of the Georgia Academy, to present this award. Dr. Yates announced that the Georgia Academy of Family Physicians had selected as the 1975 recipient W. A. Mendenhall, M.D., of Chamblee, Georgia.

Civic Endeavor Award

The Civic Endeavor Award is a special award designed to honor those physicians who are active in civic affairs. The recipient of the award is selected by a secret committee which evaluates nominations made by the county medical societies. Dr. Haverty called upon Dr. David A. Wells to make the presentation of the Civic Endeavor Award.

Dr. Wells announced that the 1975 recipient was Richard E. Smoot, M.D., Decatur, Georgia.

Distinguished Service Award

The highest honor that the Medical Association of Georgia can bestow upon one of its members in recognition of service to the Association is the Distinguished Service Award. At this point, President Haverty announced that the recipient of the 1975 Distinguished Service Award was P. P. Volpitto, M.D., of Augusta.

Following several brief announcements, President Haverty adjourned the meeting at 12:00 noon.

Augusta anesthesiologist Perry P. Volpitto is the recipient of MAG's 1975 Distinguished Service Award. The resolution nominating Dr. Volpitto came from the Richmond County Medical Society, of which he is a former president. His colleagues listed his many accomplishments and called him a "friend, comforter, advisor, teacher, physician and sometimes worthy adversary to many of us."



The prestigious award for Distinguished Service goes to Perry P. Volpitto of Augusta, (L) as presented by J. Rhodes Haverty.

Dr. Volpitto was honored previously by MAG in 1966 when he was presented the Lamartine Griffin Hardman Cup for outstanding contributions to the field of medicine.

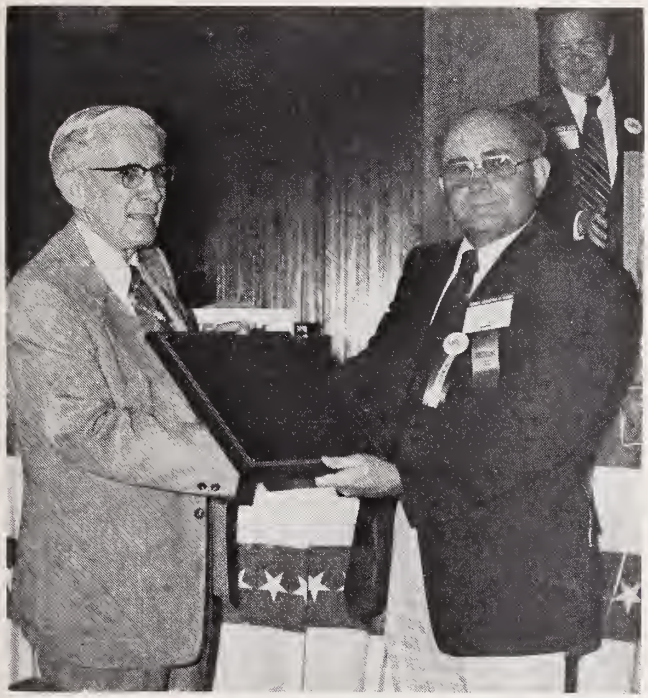
Dr. Volpitto may be best known for his work at the Medical College of Georgia which he joined as associate professor of anesthesiology in 1937, shortly thereafter establishing the first residency program in anesthesia in the South at the University Hospital. He later served as professor and chairman of anesthesiology at the college and was named Professor Emeritus in July 1973.

Dr. Volpitto is a past president of the American Society of Anesthesiologists, Georgia Society of Anesthesiologists, Association of University Anesthetists and Southern Society of Anesthesiologists. In 1974 he was presented the Distinguished Service Award of the American Society of Anesthesiologists for meritorious service and achievement in the course of his career, the highest honor of that Society.

The Italian born physician received his medical degree from Western Reserve University in Cleveland, Ohio in 1933. He served his internship and residency at Wisconsin General Hospital in Madison and Bellevue Hospital in New York City. Dr. Volpitto and his wife, Mary, have three children.

Richard H. Smoot of Decatur was nominated by the DeKalb County Medical Society for the honor of receiving MAG's Civic Endeavor Award. Dr. Smoot, now retired from active practice, has given years of service to his profession and the community.

At the state level, Dr. Smoot has served as a member of the State Board of Health for six years, and was vice chairman of the Board for the last 1½ years of his term. He was a member of the Medical Advisory Committee for the state's vocational rehabilitation program for 14 years.



Richard H. Smoot, M.D. of Decatur (L) receives the MAG Civic Endeavor Award from incoming President David A. Wells of Dalton.

Dr. Smoot became active in the DeKalb County Medical Society in its beginnings and was president in 1954. He helped to establish the first seal and wrote the first constitution and bylaws. Still active, Dr. Smoot is a member of the Ethics and Grievances Committee and chairs the Liaison Committee with Emory University School of Medicine, his alma mater. He is a delegate from the society to MAG.

His teaching career has included the post of assistant professor of gross anatomy at Emory University. For 10 years he was associate chief of surgery and physician in charge of surgical training program at Georgia Baptist Hospital. Under his leadership the Department of Surgery increased its approved residency from one to three years. He was the first chief of surgery for DeKalb General Hospital and was instrumental in writing the first set of rules and regulations for the operating room and for the formation of the original constitution and bylaws for DeKalb General. He chaired the first committee for continuing medical education.

Dr. Smoot has received recognition in other areas, too, being awarded the Bronze Star, ETO for Meritorious Service while serving in the U. S. Army during World War II. The Georgia Nurses Association named him Outstanding Doctor of the Year in 1974.

Dr. Smoot is a member of the Decatur First Baptist Church and serves as a deacon there. He is a charter member and past president of the Decatur Kiwanis Club.

William Alfred Mendenhall is the recipient of the 1975 Family Physician of the Year Award, presented by the Georgia Academy of Family Physicians (GAFP).

Dr. Mendenhall has practiced medicine in the Chamblee area since 1936, and was active in efforts to bring DeKalb General and Northside hospitals to the area. He is a past president of the DeKalb County Medical Society, and a charter member of the GAFP and American Academy of Family Physicians. In 1973 he was presented a citation and plaque honoring him as Citizen of the Year by the City of Chamblee and the Chamblee Masonic Lodge No. 44, F. and A.M.

The Oregon native received his degree in medicine from Emory University. After marrying the former Ruth Eddleman in July 1936, Dr. Mendenhall began private practice in Chamblee. From 1941 to 1957 he operated the Chamblee Hospital, taking one year out in 1953 to get additional training in surgery at Crawford W. Long Memorial Hospital. His career has seen the delivery of over 3,000 babies and his performance of 2,000 major operations.



Family Physician of the Year is W. H. Mendenhall (L), congratulated by A. J. Yates of Soperton representing the Georgia Academy of Family Physicians.

Second Session House of Delegates

Sunday, April 20, 1975

THE SECOND SESSION of the House of Delegates of the Medical Association of Georgia's 1975 Annual Session Business Meeting was called to order at 9:00 a.m. by Speaker L. C. Buchanan, M.D., Decatur, in the Ballroom of the Fairmont Colony Square Hotel, Atlanta, Georgia, on Sunday, April 20, 1975.

The Speaker called upon Dr. Louie D. Newton, Pastor Emeritus of the Druid Hills Baptist Church of Atlanta, for the invocation.

Speaker Buchanan called for report on attendance and Thomas Douglass, M.D., speaking for the Credentials Committee, reported that in excess of 40 delegates was present and that a quorum was present and, therefore, the House could proceed with its business. Dr. Douglass subsequently reported that 158 delegates were present at the Second Session.

(The Credentials Committee made the following complete report on attendance at the close of the meeting.)

Attendance

In the compilation of attendance taken from the official roll, 161 delegates were present at the Second Session. They were as follows:

BALDWIN: Edwin W. Allen, Jr. and W. T. Smith; BARTOW: R. A. Griffin, III; BIBB: Jimmy Asbell, Rodney M. Browne, John G. Etheridge, Warren Griffin, Jasper T. Hogan, Jr., Jack F. Menendez, W. John O'Shaughnessey and Beverly B. Sanders, Jr.; OGEECHEE RIVER: Leon E. Curry; BURKE: Walter R. Voyles; CARROLL-DOUGLAS-HARALSON: Clark Robinson; GEORGIA MEDICAL SOCIETY: Carson B. Burgstiner, J. Patrick Evans, Frank M. Johnston, J. Moultrie Lee, Robert Logan, Debele Maner, Joseph V. Morrison, D. N. Nash and Charles Usher; ELBERT: McAlpin H. Arnold; CHATTAHOOCHEE: Rupert H. Bramblett and Cecil L. Miller; CHEROKEE-PICKENS: L. Austin Flint; CRAWFORD W. LONG: Edward L. Lewis and A. D. Muse; CLAYTON-FAYETTE: William McDavid; COBB: Robert P. Coggins, Philip Z. Israel, Frank W. McKinnon, James H. Manning, J. Gary Palmer, Harry Porter, Charles J. Rey, Donald R. Rooney and Dan B. Stephens; COLQUITT: John P. Tucker; DEKALB: Stanley P. Aldridge, H. Duane Blair, L. C. Buchanan, L. L. Freeman, John P. Heard, James Joiner, Charles W. McDowell, Jr., LaMar S. McGinnis, Richard Smoot, Ralph A. Tillman and Roy W. Candiver; DOUGHERTY: J. D. Bateman, D. M. Boyette, Charles D. Hollis and Robert D. Waller; EMANUEL: R. J. Moye; FLOYD-POLK-CHATTOOGA: Louis S. Hajosy, J. R. Meacham, C. O. Sennett and James H. Smith; FRANKLIN-HART: Weldon Williams; MEDICAL ASSOCIATION OF ATLANTA: Thomas J. Anderson, Jr., John S. Atwater, J. Norman Berry, Linton H. Bishop, E. Napier Burson, William C. Collins, R. Carter Davis, Brown Dennis, F. W. Dowda, Edwin C. Evans, Louis H. Felder, Joseph L. Girardeau, Irving L. Greenberg, John C. Hall, Charles E. Harrison, Jr., J. Harold Harrison, John Rhodes Haverty, Armand Hendee, William E. Huger, Jr., Fleming L. Jolley, W. D. Jordan, James A. Kaufmann, William D. Logan, John R. McCain, John M. McCoy, William W. Moore, C. R. Moorhead, Keith A. Quarterman, Harrison L. Rogers, Jr., John K. Schellack, David S. Sowell, William B. Spearman, Paul Teplis, Hugh Thompson, Thomas L. Tidmore, Charles E. Todd, L. Newton Turk, B. F. Voljavec, William C. Waters, Robert E. Wells, Douglas Whitney, Frank Wilson and Joseph S. Wilson; GLYNN: M. A. Glucksman, Edwin A. Mayo and W. Jack Smith; GORDON: R. D. Walter; HABERSHAM: Thomas N. Lumsden; HALL: Charles K. Bradley, Lawrence L. Durisch, John W. Garland, III, and Harvey M. Newman, III; PEACH-BELT: H. E. Weems; JACKSON-BANKS: E. W. Holloway; LAURENS: O. B. Johnson and Robert W. Oliver; MUSCOGEE: Marvyn D. Cohen, John H. Deaton, Bob R. Maughon, E. M. Molnar, Bruce Newsom, Jack A. Raines and James H. Sullivan; NEWTON-ROCKDALE: Ragilio Bonau; OCONEE VALLEY: H. A. Thornton; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Joseph P. Bailey, William E. Barfield, Claud A. Boyd, Albert A. Carr, Thomas G. Douglass, Ronald F. Galloway, Julius T. Johnson, J. Kenneth McDonald, John M. Martin, John Phinizy, Stuart Prather, Luther M. Thomas, Jr., and Charles H. Wray; SOUTH GEORGIA: F. G. Eldridge and Joe C. Stubbs; SPALDING: Henry A. Foster and James M. Skinner; STEPHENS-RABUN: C. Peter Lampros; SUMTER: E. W. Waldemayer; THOMAS AREA: William A. Trevejo, F. R. Miller and Gerald B. Muller; TIFT: Robley D. Smith; TROUP: Joseph M. Almand, Jr. and H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Ted D. Cash and M. K. Cureton; WARE: S. William Clark and Floyd Davis; WHITFIELD-MURRAY: John G. Forshner, James J. Oosterhoudt and Sydney Sellers.

Affiliate Membership Election

The Speaker announced that Robert Wright Jackson, III, D.D.S., of Thomasville had been proposed for affiliate membership by the Thomas Area Medical Society and that the Council had approved Dr. Jackson's membership at its previous meeting on April 17. Pursuant to Chapter I, Section 5, of the Bylaws, only the House of Delegates has the authority to finally elect a member to affiliate membership.

Accordingly, Speaker Buchanan put Dr. Jackson's name before the House and the House elected him to affiliate membership in MAG.

Elections

Ballots were distributed to the members of the House and the Speaker then explained that write-in ballots could be cast for any office.

The Speaker then read the names of the nominated candidates for each office and requested the members of the House of Delegates to vote for one candidate for each office. The candidates by office were, for President-Elect: Fleming L. Jolley; for Second Vice President: James H. Sullivan and John P. Heard; for Secretary: Earnest C. Atkins; for Treasurer: Carson B. Burgstiner; for AMA Delegate (Chambers' seat): C. E. Bohler; for AMA Delegate (Atwaters' seat): F. William Dowda and Luther M. Vinton; for AMA Alternate Delegate (Eldridge's seat): F. G. Eldridge; for AMA Alternate Delegate (Vinton's seat): Charles D. Hollis and John P. Heard; for AMA Alternate Delegate (Bohler's seat): H. Hilt Hammett; for AMA Alternate Delegate (Dowda's seat): William W. Moore; for Ninth District Councilor: Harvey Newman; for Ninth District Vice-Councilor: L. Austin Flint; for Tenth District Councilor: Edwin W. Allen; for Tenth District Vice-Councilor: M. A. Hubert.

At this point, the ballots were collected by the Tellers' Committee and the counting of the ballots followed.

Reference Committee Reports

Speaker Buchanan called for reports from the Reference Committee Chairmen. He reiterated his earlier remarks at the First Session that at the conclusion of each section of the Reference Committee report, the House would, at that point, be given an opporunity to discuss and ultimately to vote on that section.

REPORT OF REFERENCE COMMITTEE A

Robert W. Oliver, M.D., Chairman

Chairman Oliver reported to the House that reports and resolutions referred to Reference Committee A had been considered by the committee which met at 1:30 p.m. in the Waterford Room in the Fairmont Colony Square Hotel, Atlanta, Georgia, on April 18, 1975. Members of the Reference Committee present included Robert W. Oliver, M.D., Dublin, Chairman; J. Kenneth McDonald, M.D., Augusta, Vice Chairman; Richard H. Smoot, M.D., Decatur; Clark Robinson, M.D., Douglasville; L. L. Durisch, M.D., Gainesville; and Keith A. Quarterman, M.D., Atlanta.



Reference Committee A

PRESIDENT

J. Rhodes Haverty, M.D.

Since reports of the various officers, councilors, and committee chairmen are made regularly and completely to this House, and since these reports include most of the important activities of the Association for the preceding year, there is little for the president to do in his report to you other than to highlight, to emphasize, and to point with pride to what others have accomplished. Thus, with that viewpoint in mind, I should like to comment on some areas of accomplishment of this Association that I think notable.

Reorganization of the Medical Association of Georgia received greater impetus under the capable leadership of your incoming president and his committee, as well as by the Unicoi meeting on this subject held in October.

Liaison and fruitful dialogue between the MAG and others has taken place consistently and with greater emphasis during this past year. Discussions and meetings with Blue Cross of Atlanta and Columbus, the Georgia Hospital Association, the Georgia Medical Care Foundation and the Metro Atlanta Foundation, editorial staffs of the major newspapers within our state, the Georgia Podiatry Association, the Georgia Nursing Association, legislators and educators, both within the state of Georgia and nationally, and with numerous other groups and individuals have produced meaningful results, and paved the way for closer working relationships toward solving problems of the future.

Your Association has hired two additional Assistant Executive Directors: one for education and one for administration, allowing our already capable staff to become even more so, both in breadth and depth. A Health Manpower Study has been instigated by the Research and Development arm of the MAG. Results from this should trigger additional activity on the parts of the MAG and others in defining our needs in Geor-

gia so that we may make meaningful attempts at correcting them.

Policy statements and position papers of the MAG have been put together and are available for all who wish to know the official position of the MAG on certain issues.

Legislative activity, always broad and effective, has continued as an integral and important part of the work of the MAG staff and many of you. GaMPAC, under the leadership of Dr. and Mrs. Dan Bateman has expanded itself and is even more effective than before. Efforts initiated by the Medical Association to alleviate the growing crisis of malpractice insurance are being carried forth.

Various other activities related to Research and Development, the Georgia Regional Medical Program, cancer and the increasing federal and state activities related to this subject, PSRO, and Peer Review may be found in other individual reports in this Handbook and in the Proceedings which will be published in June.

Our Education Committee, under Dr. Davies, is doing a magnificent job in many areas. It is interesting to note in reviewing presidents' reports for the past ten years or so how much a percentage and how frequently these columns reflect interest in and concern about educational goals and objectives for medicine and the allied health fields. So much activity has taken place in this important committee during the past year, that I can only commend the committee, and commend to you its report.

As I leave this high office I wish to make special note concerning my deep appreciation for some specific individuals. On the staff, my close working relationship with Mr. Moffett, Mr. Jablonowski, Mrs. Wooten, Mr. Storey, Miss Morse, and Miss Oliver have made what could have been choresome and difficult a most rewarding and pleasant job. In not naming other highly qualified, resourceful and helpful members of our fine staff is in no way detracting from their efforts in behalf of us all and particularly to me. The ones mentioned, however, have gone far far beyond what I could have asked of them.

Similarly I would like to name specifically some of you who have done so much for this Association over the years, and with whom I have had such great pleasure in serving over the years. Again by not naming some, I mean no disrespect whatever, but only wish to pay special tribute to these. To our Past President, Emory Bohler, to our Secretary, Ernie Atkins, to our Treasurer, Bucky Burgstiner, to our councilor and Composite Board member, Buster Deal, to our councilor and regent, Bud Robinson, to our councilor and fellow writer, Luke Vinton, to our delegates, Red Chambers, John Atwater, and Jack Rogers, to our Finance Chairman, Tex Eldridge, to our Education Chairman and my physician, Nick Davies, to our State Legislative Chairman, Jim Kaufmann, I extend my warmest, most sincere, and heartfelt thanks for your help, your friendship, and for your dedicated work in behalf of our beloved Association.

And lastly, may I extend again my thanks, my assurance of continued interest and work in behalf of us all, and my encouragement and affection to our very capable incoming leader, Dr. David Wells.

Thank you all.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee noted with special interest the observations made in the report of the President. Mr. Speaker, your Reference Committee recommends approval with commendation of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the President.

SECRETARY

Earnest C. Atkins, M.D.

REFERRED TO:

Ref. Comm. F—Recommendation 1
Ref. Comm. A—Recommendations 2, 3, 4, 6
Ref. Comm. D.—Recommendation 5

The Medical Association of Georgia has had another great year. Our Association is a true leader and continues to increase in quality and quantity, regarding membership and medical care related to the health of all Georgians.

Membership Report

	1973	*1974*
Active	3,465	3,738
Active I & R		24
DE-1	63	59
DE-2	21	19
DE-4	10	11
LIFE	179	167
ASSOCIATE	111	133
SERVICE	65	55
HONORARY	1	1
AFFILIATE	1	1
STUDENT	1	2
	3,917	4,210

AMA Membership

1973	*1974*
3,190	3,264

The membership of the Medical Association of Georgia continued its upward climb during the year 1974. The rate of growth slightly increased over the previous year. This is its highest membership in the history of the MAG. Our AMA membership is also at an all time high of 3,264 as compared to 3,190 in 1973.

Although we had a good membership year, both at MAG and AMA, the big concern is the 1,500 Georgia physicians that are not members. The membership age is also increasing so we must interest the younger physicians, residents, interns, and medical students in organized medicine. There is our leadership of tomorrow. At the end of this effort, I will make recommendations to increase our membership.

GEORGIA REGIONAL MEDICAL PROGRAM

There will be a separate report by the House of Delegates by the Coordinator of the Regional Medical Program covering GRMP activities during the past 12 months. Although this program will probably be phased out, there is continued negotiation by the Federal Government and Georgia leadership in this field under the capable direction of J. Gordon Barrow, M.D., Director of the Program.

A close liaison continues to exist between your Secretary, Dr. Barrow and their respective staffs.

It was with regret that Charles Adair, M.D., Rome, Georgia, resigned as Coordinator, but we were fortunate to find a dedicated, hardworking physician, Luther M. Vinton, M.D., Avondale Estates, Georgia, to replace him.

CHAMPUS PROGRAM

The MAG CHAMPUS Program continues to be exemplary of the better programs of this type in the nation. The Department of Defense, as well as the physician and patients, are well satisfied with the processing of claims which MAG supervises. Joyce Butler, R.N., CHAMPUS Administrator, and her staff are to be commended. There is an ever increasing number of claims and work load and a statement report follows (see attachment).

MAG FOUNDATION

The MAG Benevolent Foundation also continues to expand. The bank balance as of 12-31-73 was $10,-381.47, as compared to the balance on 12-31-74 of $11,641.67.

The Foundation continues to serve some needs previously not served and consolidating others. The Foundation is well established and will continue to grow in size and importance to our membership.

The present trustees for the year 1975 are as follows:

John T. Mauldin, M.D.
J. Rhodes Haverty, M.D.
Charles R. Andrews, M.D.
Earnest C. Atkins, M.D.
Mr. James M. Moffett
Mr. Winston Huff

WATS LINE

This toll free telephone service has been another link between the membership and the headquarters office.

GEORGIA MEDICAL CARE FOUNDATION

A separate report is given by Mr. Gus Anderson, who recently resigned, and he deserves our sincere thanks for a job *well done*. The Foundation continues to be in good hands with Mr. John Voigt, the new Executive Secretary, and Mr. Jim Moffett as Executive Director of the Foundation. A recommendation will be made at the end of this report.

HEADQUARTERS OFFICE

The headquarters building is less crowded for space now that EMCRO and GRMP activities are being curtailed.

Our Headquarters Office staff continues to grow in

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
GEORGIA
1973-1974 STATISTICAL REPORT

Claim Flow	Annual 1973	Annual 1974	Per Cent Totals 1973	Per Cent Totals 1974	Per Cent of Annual Change 1973-1974
I. Number Claims Received					
1. Inpatient	28,413	32,933	37.0	35.0	15.9 +
2. Outpatient	38,480	49,427	50.0	52.5	28.5 +
3. Handicap*		624		0.7	
Subtotal	66,893	83,002	87.0	88.2	24.1 +
4. Drugs†	97,046	11,156	13.0	11.8	14.5 +
Total	76,639	94,158	100.0	100.0	22.9 +
II. Returned	9,698	11,018	12.94	13.40	13.6 +
III. Rejected	9,225	11,403	12.31	13.86	23.6 +
IV. Review Committee	84	60	0.11	0.07	28.6 –
V. No. Claims Paid					
1. Regular	47,865	51,108	63.85	62.15	6.8 +
2. Handicap*	878	673	1.17	0.82	23.3 –
3. Drugs	7,212	7,976	9.62	9.70	10.6 +
Total	55,955	59,757	74.64	72.67	6.8 +
VI. No. Claims Processed	74,962	82,238	100.0	100.0	9.7 +
VII. Funds Disbursed					
1. Regular	$4,744,568.24	$5,139,043.10	89.7	90.8	8.3 +
2. Handicap	317,971.92	249,000.90	6.0	4.4	21.7 –
3. Drugs	226,957.00	274,024.13	4.3	4.8	20.7 +
Total	$5,289,497.16	$5,662,068.13	100.0	100.0	7.04+
VIII. Average Disbursements per Claim					
1. Regular	99.12	100.55			1.4 +
2. Handicap	362.15	369.99			2.7 +
3. Drugs	31.47	34.36			2.0 +
Total	94.53	94.75			.23+

* 1973 Handicap Claims were included in with the Inpatient and Outpatient Totals
† Reimbursement and Vendor

number with the addition of Mr. J. Sherwood Williams, Assistant Executive Director, Administration, Steve Daniel, Ph.D., Assistant Executive Director, Education. The growth of these activities is considerable but should be considered a service to our members and their patients. The total personnel at MAG in the various related activities sponsored by MAG is 124. A breakdown of the personnel is as follows:

	1973	*1974*
GRMP	27	27
CHAMPUS	18	25
MAG (including Secretary, Treasurer, and JMAG Editor)	18	18
GMCF	33	33
	96	103

The personnel picture is more stable at this time and the average length of service is 51 months. The programs and projects continue to increase and function smoothly in a manner that reflects credit on the medical profession and its Association.

Service to our membership should be the number one priority. We should make this program so attractive and well publicized among the physicians of Georgia so that the 1,500 new members of MAG will have others to join our Association. To this end I have the following:

RECOMMENDATIONS

1. No increase in dues this year but to operate MAG efficiently and economically, so when a dues increase is imperative, we can show the members that we have cut the expenses to the bone. This will also help retain any present members as in our new membership drive.

2. Direct the Executive Committee to institute a membership drive through the Membership Committee and staff. A plan has already been formulated for this and an additional 1,000 new members may be ambitious but not impossible. The work our Insurance Committee does for malpractice insurance alone save us enough money to pay our annual MAG dues. Also, St. Paul does not cancel the malpractice coverage on any of our members without having the case investigated by our Insurance Committee. This information as well as all our positive programs should be distributed to our present members as well as our prospective members. In the areas where we are serving our members well, let's tell them about it. With every contact the staff or leadership makes—let's recruit new MAG members.

3. Direct the Executive Committee to have the Insurance Committee to develop an insurance program for all types of insurance for our members similar to the one with the Florida Medical Association or the Alabama Medical Association. This too should be sold to our members and prospective members and show the savings MAG is passing on to them. Also through group plans some members can be insured who otherwise would not be eligible for certain types of insurance. The Southern Medical Association's insurance program keeps it going. I think we can and should develop a good insurance program for our members.

4. Direct the Executive Committee to appoint an Ad Hoc Committee to study the feasibility of MAG doing our own printing such as prescription blanks, stationery, bills, etc. This could be a financial savings to our members and maybe cover some expenses for the Headquarters Office if vacant space is available. This could be another service to our membership. This is done in Alabama and other states.

5. Direct the MAG to have unified membership which would require a Constitution and Bylaws change. This would increase the membership so if a member joins a county society he would also join MAG. This will increase income from dues, thus delaying a dues increase. MAG charters the county medical societies so it is reasonable to require membership in the chartering institution when a member joins the county society.

6. Direct the Council to investigate the change of the GMCF from a corporation to a Committee of MAG. The tax exempt status is important and any disadvantage should be considered. This change would be very economical because the GMCF structure under MAG will save top level executives. Also, when space is available in the MAG office building the GMCF could be relocated here.

All of these recommendations are aimed at serving our membership effectively, and economically and making membership in MAG so desirable that no M.D. can afford not to belong.

(Recommendations 2, 3, 4 and 6 were considered by Reference Committee A.)

REFERENCE COMMITTEE RECOMMENDATION —Reference Committee A's attention was drawn to four recommendations in the Secretary's report, and they are as follows: Recommendation 2 deals with membership. Your Reference Committee would recommend the approval of Recommendation 2, with one change. In the fourth sentence, beginning, "Also, St. Paul does not . . . ," your Reference Committee recommends that the words, "St. Paul," be deleted, and the word "carrier" substituted. The Reference Committee thought it was inappropriate to mention the name of a commercial operation in this report.

Your Reference Committee recommends approval of Recommendation 3, dealing with an insurance program similar to Florida and Alabama, with the following deletion and substitution: In the first sentence, beginning, "Direct the Executive Committee to have Insurance Committee to develop an insurance program," your Reference Committee recommends the deletion of the words, "to develop an insurance program," and would recommend the following; "to investigate the development of an insurance program for all types of insurance." Therefore, the sentence would now read: "Direct the Executive Committee to have the Insurance Committee to investigate the development of an insurance program for all types of insurance for our members, similar to the one of the Florida Medical Association or the Alabama Medical Association.

Your Reference Committee recommends the approval of Recommendation 4, of the Secretary's report, which recommends a feasibility study for a printing operation.

It is recommended that Recommendation 6, which would change the GMCF to a Committee of MAG, be disapproved. Your Reference Committee has taken note of the MAG Council's continuing interest and

ongoing monitoring of the Georgia Medical Care Foundation's activities and feels that the Recommendation is unnecessary.

HOUSE OF DELEGATES ACTION—Recommendation 2 of the Secretary was approved as amended by the Reference Committee. Recommendation 3 of the Secretary was approved as amended by the Reference Committee. Recommendation 4 of the Secretary was approved. Recommendation 6 of the Secretary was disapproved.

COUNCIL

Fleming L. Jolley, M.D.

REFERRED TO:

Ref. Comm. A—Recommendation 2
Ref. Comm. D—Recommendation 1
Ref. Comm. F—Recommendation 3

The purposes of this association are to promote the science and art of medicine and the betterment of public health. The duties of Council are to carry out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws (Article II and Article VI, Section 2, MAG Constitution).

Agendas, previous Council and interim Executive Committee minutes have been mailed to all Councilors and Vice Councilors three weeks preceding Council meetings. Such background information should have provided adequate time for its dissemination to component medical societies.

Quality care and the availability of that care is the collective responsibility of this association. The enactment of recent legislation significantly influences the methodology of health care delivery. The legal society is increasing its influence on this delivery system.

Response of Council to action of 1974 House of Delegates:

1. *Access to Medical Care:* Special committee appointed (see report—Dr. Adair).
2. *Employment of Education Coordinator:* Dr. Stephen Daniel.
3. *Formation of Finance Committee of House of Delegates:* (See Report of Committee on Constitution and By-Laws—Dr. Mauldin).
4. *Reapportionment of House of Delegates:* (See report of Committee on Organization—Dr. Wells).
5. *Health Manpower Study:* A comprehensive study of the physicians in Georgia was approved with a budget of $4,400.00 (see Report of Committee on Access to Health Care—Dr. Adair).
6. *Peer Review Mechanism:* An Ad Hoc Committee to evaluate (see Report of that committee—Dr. McCain).
7. *Appoint Committee on Physician's Assistants:* (See Report of that committee—Dr. John P. Wilson).
8. *Research and Development Arm of MAG:* Appointed committee recommended formal establishment of such an arm with funding of the directors and appropriate staff is to be budgeted by the Finance Committee, February, 1975, as follows:

RESEARCH AND DEVELOPMENT

The 1974 House of Delegates recommended that Executive Committee investigate the need for a research and development arm of the Association and report their findings to the 1975 House of Delegates. Inasmuch as Executive Committee does not report directly to the House of Delegates, it makes the following report to Council (Council reports have direct access to the House).

At the September meeting of Council, you requested more details on the cost of a research and development arm. The following is that report:

Budget

The costs associated with meeting the above responsibilities are reimbursable by the federal and state government and other funding agencies. They must be charged as *indirect* administrative costs, however, rather than *direct* project expenses. As the indirect cost reimbursement rate is calculated based on the institution's previous year's administrative expenses, it is necessary for MAG to budget for this administrative activity and actually expend these funds before reimbursement begins. The following budget is proposed in order to support these activities effective June 1, 1975. Details of this budget will be presented to the Finance Committee.

Personnel	21,000
Travel	4,000
Postage	200
Telephone	400
Xeroxing	300
Office Supplies	300
Publications	600
Conference Registration Fees	600
Equipment Maintenance Contracts	1,000
	28,400

An administrative structure for Research and Development would be created, with the following purpose:

> To seek and negotiate funding for—and administer—research and development projects.

The Director of Research and Development would have the following responsibilities:

A. Identify research and development funding sources by:
   1. Review of publications
   2. Attendance at conferences
   3. Maintaining contact with potential funding agencies
B. Prepare technical proposals through:
   1. Appropriate MAG Committee
   2. Designated Principal Investigator
C. Prepare business proposals
   1. Insure availability of resources
   2. Allocate resources
   3. Develop budget
D. Insure review of proposals by:
   1. Appropriate MAG Committee
   2. Executive Committee

E. Represent MAG in research and development matters:
   1. Bidders conferences
   2. Site visits
   3. Negotiations on terms of funding, etc.

F. Provide administrative control for all research and development projects:
   1. Fiscal
      a. Review purchase orders of all projects prior to submission to Director of Finance to insure appropriateness and reasonableness
      b. Review monthly project financial statements with project directors
      c. Arrange for purchase or lease of all project equipment, computer time, sub-contract work, etc.
      d. Maintain records and controls over inventories of materials, supplies and equipment
   2. Personnel
      a. Develop job descriptions for research and development staff
      b. Interview and hire research and development staff
      c. Administer MAG personnel policy to research and development staff
   3. Other Administrative
      a. Allocate and monitor project use of shared resources and capabilities
      b. Insure compliance with applicable federal, state, local, and institutional policies and regulations

G. Monitor progress of research and development projects
   1. Review progress reports and final reports
   2. Require interim reports as necessary
   3. Report to MAG

H. Insure coordination of research and development projects with other MAG staff and committee activities

9. *PSRO:* (Public Law, October, 1972): Funding in the form of (1) planning grants, and (2) conditional grants began June, 1974, and (3) establishment of PSRO support centers began June, 1974.

Efforts for repeal have been totally unsuccessful to date. Council, following AMA action in September, 1974, voted to cut back the MAG campaign to repeal the law. Council reported a proposal by Executive Committee to recommend to the House of Delegates that MAG or its subsidiary make application to be the PSRO in Georgia. Council requested the PSRO Committee to obtain by written questionnaire from every member of MAG a response for House of Delegates considerations in April, 1975.

If MAG does not submit grant request, another organization will be selected and empowered to direct the program in Georgia by 1976. Currently this state is considered for one PSRO but could be three. Rest assured there are those who would like nothing better than to have MAG default this responsibility.

The Georgia Medical Care Foundation has grown in stature. As members of specialty and subspecialty organizations, the input is needed to maintain a viable, cohesive approach in those areas responsive to both the Medical Association of Georgia and its constituent county medical societies and their own foundations.

If priorities can be designated, these should be developed:

1. *Professional Liability Insurance*—there is need of legislation at the state level (see Report of Committee on Insurance & Economics—Dr. Moore).
2. *Health Maintenance Organizations* (See Report of that committee—Dr. Underwood).
3. *National Health Planning and Development and Health Facilities Assistance Act of 1974.*
4. *PSRO*
5. *Reorganization of MAG structure*
6. *Utilization Review Mechanisms*
7. *Membership*

These are not necessarily listed in order of a priority rating.

The pleasures of serving as Chairman of Council this year are known to but those having so chaired this esteemed group. I express my thanks to each one who has come and to each one who has represented you vocally or in silence. It is an interesting revelation to those of you not working more closely with "staff" (the laymen of this organization) of what they do. Why they do it? Ask them. It's not a 40 hour (5 day a week) job. My personal thanks to Jim Moffett, Catherine Wooten, L. B. Storey, Rusty Kidd, Adam Jablonowski, Gus Anderson, Lowell Foster, Sherwood Williams, Stephen Daniel, Sylvia Barnes, and all the others who do the leg and paper work.

RECOMMENDATIONS

1. That the House of Delegates continue to refer significant recommendations to Council for proper implementation.
2. Enhance MAG membership through positive action.
3. Accept the Research and Development Component of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee was asked to review Recommendation 2 of the Chairman of Council's report, dealing with membership, and would request that House approve this Recommendation with the following amendment: It is further recommended that a system be developed to identify new physicians coming into Georgia and make a concerted effort through all available means to enlist these new physicians as MAG members. It is further recommended that all county medical societies be encourage to initiate new member indoctrination programs.

HOUSE OF DELEGATES ACTION—Approved Recommendation 2 of the report of the Chairman of Council as amended by the Reference Committee.

THIRD DISTRICT COUNCILOR

JOHN H. ROBINSON, III, M.D.

I regret that I have been unable to attend the meetings as regularly as I usually do. This absence was caused by conflicts or circumstances that I could not change. I hope to do better this year.

In my opinion, as the practice of medicine is being regulated by more and more agencies, it is high time that we:

RECOMMENDATIONS

1. Rededicate ourselves in every way possible and to the best of our ability to see that every patient can continue his free choice of physician and be provided with the very best medical care.

2. We should dedicate our efforts to see that every physician, urban, semi-urban, or institutional should be treated and paid the same for the same service. The Medical Association should assist in every way possible. It has been suggested to me that legal measures be taken, should it become necessary.

3. We should also continue in our efforts to provide a more equitable distribution of doctors.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Flint				
J. T. Christmas				
Vienna	13	12	15	12
Peach Belt				
C. Ray Ivey, Jr.				
Warner Robins	40	35	41	38
Randolph-Stewart-Terrell				
John G. Bates				
Cuthbert	10	10	8	8
Sumter				
William R. Anderson				
Americus	27	18	20	17
	90	75	84	75

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of Recommendation 1 of this report, which addresses itself to rededication of physicians to provide the best of medical care.

Under Recommendation 2, your Reference Committee would recommend approval with the following amendment: In the first sentence, after the words, "urban, semi-urban," would recommend the insertion of the word "rural," then, the sentence would continue, ". . . or institutional." After "institutional," we would recommend the substitution for the rest of the entire sentence, which would now read, "should be paid a fee for service without regard to geographic location." So, the recommendation to that point would now read, "we should dedicate our efforts to see that every physician, urban, semi-urban, rural, or institutional, should be paid a fee for service without regard to geographic location." In the next sentence of Recommendation 2, stating, "The Medical Association of Georgia should assist in every way possible," your Reference Committee would add to this sentence the words, "to implement this policy." So the sentence would now read, "The Medical Association of Georgia should assist in every way possible to implement this policy." It is further recommended that the entire last sentence of Recommendation 2 be deleted.

We would recommend the approval of Recommendation 3, with the following amendment: To the end of the sentence, "Distribution of Doctors," we would recommend the addition of, "to relieve shortages in under-served areas." The sentence would now read, "We should also continue in our efforts to provide a more equitable distribution of doctors to relieve shortages in under-served areas."

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 of the Third District Councilor. Recommendation 2 approved as amended by the Reference Committee. Recommendation 3 approved as amended by the Reference Committee.

RESOLUTION 1-75

MEDICAID PAYMENTS

James C. Dudley, M.D., Delegate, Sumter County Medical Society

WHEREAS, there exists a shortage of physicians in rural areas which could possibly be overcome if an adequate income could be expected by physicians entering practice and considering a rural location; and

WHEREAS, physicians practicing in rural areas are discriminated against under Medicaid because of the lesser fees paid to rural practitioners; and

WHEREAS, because of the discriminatory payments, many physicians refuse to accept Medicaid patients, now therefore be it

RESOLVED that the MAG make every effort at the national and state level to change the pertinent laws and regulations applicable to Medicaid so that standard and equal fees would be paid under the Medicaid Program for services performed by physicians irrespective of geographical location, duration of practice, past profiles, or any other arbitrary distinctions; and be it further

RESOLVED that MAG submit a similar resolution to the AMA seeking their support for obtaining these changes in the federal law and regulations.

REFERENCE COMMITTEE RECOMMENDATION —It is recommended by your Reference Committee that you disapprove Resolution 1-75, from the Sumter County Medical Society, since the subject has been adequately addressed in the amended report of the Third District Councilor.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 1-75.

RESOLUTION 10-75

MEDICAID PAYMENTS

Crawford W. Long County Medical Society

WHEREAS, the current method of reimbursement for Medicaid patients and services along lines currently used by Medicare as outlined in a letter from the Department of Human Resources and dated 3/24/75; and

WHEREAS, the prevailing method of disbursement does not take into consideration the inflationary trends since 1970; and

WHEREAS, the fee schedule is discriminatory since the legislature did not use the same formula in raising their salaries last year, nor when awarding contracts for highways and other state procurements, does the legislature expect 75 percentile bids of 1970-1974 prices; therefore be it

RESOLVED, that the House of Delegates take steps to protest this action through proper state channels.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this Resolution, with the deletion of the entire third "Whereas" section of this resolution. The Resolution would now read, "Whereas, the current method of reimbursement for Medicaid patients and services along lines currently used by Medicare, as outlined in a letter from the Department of Human Resources, and dated 3/24/75; and Whereas, the prevailing methods of disbursement does not take into consideration the inflationary trends since 1970. Resolved, that the House of Delegates take steps to protest this action through the proper state channels."

HOUSE OF DELEGATES ACTION—Delegate F. William Dowda moved that the last "Resolved" be amended by deleting the word "state" and adding to the end of the "Resolved" the words "via AMA resolution." The House of Delegates then approved Resolution 10-75 as amended by the Reference Committee and as amended on the floor.

COMMITTEE ON ACCESS TO HEALTH CARE

M. C. Adair, M.D.

REFERRED TO:

Ref. Comm. A—Recommendations 2, 3, 4
Ref. Comm. F—Recommendation 1

The Committee met on Sunday, December 8, 1974, and discussed the charge to the Committee given by the House of Delegates in May 1974. In discussing the situation where communities desire a physician it was noted that there were actually no standards or criteria upon which to evaluate the need. A questionnaire was being developed to determine if a shortage or maldistribution of physicians exists.

The Committee recommended to the MAG Council that a review be made of the efforts of the Georgia Council for Family Practice Education to obtain funds to support family practice education supported by the State of Georgia. Subsequent to this action, it was found that under the State Constitution funding cannot be implemented for residency programs in community hospitals without a major change in the State Constitution. Apparently, the only funds that can be made available would come through the State Board of Regents. At this point in time, the State of Georgia will be unable to keep pace with similar efforts in Florida and South Carolina. The Committee could identify no additional new factors in this very old and real problem in answer to health care.

RECOMMENDATIONS

1. That the Manpower Study proposed by the Medical Association of Georgia be implemented in July 1975 lasting two months and that a budget of $5,000 (a copy of which is appended) be applied to this Manpower Study utilizing the services of Mr. John Harrington.

2. That the Medical Association of Georgia continue to support the Georgia State Medical Education Board.

3. That the National Health Service Corps placement of physicians in problem areas be considered.

4. That the Medical Association of Georgia endorse the efforts to produce more family physicians, and if necessary support legislation efforts to fund such programs.

COMMITTEE ON ACCESS TO HEALTH CARE

Manpower Study Budget
June, 1975-August, 1975

	Salary	*Fringes*	*Total*
Personnel	$2,805	$390	$3,195
John Harrington 100%			
Supplies			60
Travel			300
EDP Services			841
Postage			20
Publications			50
Telephone			60
Indirect Costs			474
			$5,000

(Recommendations 2, 3 and 4 were considered by Reference Committee A.)

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee was tasked with the review of Recommendations 2, 3, and 4, of this report. Your Reference Committee recommends approval of Recommendation 2, regarding support of the Georgia Medical Education Board. Your Reference Committee recommends approval of Recommendation 3, regarding National Health Service Corps.

Your Reference Committee recommends approval of Recommendation 4, with the following amendment: Recommended that the last two words, "such programs," be stricken, and the following substitution be made, "family practice residency programs." Therefore, the Recommendation would read, "The Medical Association of Georgia endorse the efforts to produce more family physicians, and if necessary, support legislative efforts to fund family practice residency programs."

HOUSE OF DELEGATES ACTION—Adopted Recommendation 2 of the Committee on Access to Health Care. Recommendation 3 adopted. Recommendation 4 adopted as amended by the Reference Committee.

COMMITTEE ON COMMUNICATIONS

Robert P. Wight, M.D.

The year 1974-75 has seen this committee continue to build on positive programs developed in the past and to develop new ones. Major gains have been made in the areas of new member contacts and general increased awareness of MAG activities by our members as well as the public in general.

For the membership, we have published a media code of cooperation. This brochure will guide doctors, hospitals and the media in bettering their relationships. Additionally, the committee, through staff, has maintained close liaison with the State Board of Medical Examiners. This liaison has promoted a free exchange of ideas and information plus giving us the opportunity

for direct contact with every new doctor licensed in Georgia.

The MAGNET '74 Conference under direction of committee member Marvyn Cohen was an outstanding success. Over 220 people registered for the program. Managing the modern medical practice was the theme of MAGNET '74.

Our greatest gains have been in the public areas of our activities.

Media relations continue to be good with an accelerated contact program generating the increased coverage of medical matters in the state. During the year we have had requests for newspaper article information and for members to appear on statewide television programs.

During the year the communications staff has arranged for the MAG President to be interviewed by editorial boards in Atlanta, Savannah and Macon. Other such meetings are planned for the other major media outlets in the state.

For the second year we produced and distributed public service announcements to all Georgia radio stations. These 60 second spots cover a wide variety of health issues and have received excellent response from all over the state.

The committee, in co-sponsorship with the AMA, has presented a practice management workshop for senior residents.

During the coming year the Communications Committee will continue to monitor public attitudes and look for opportunities to present medicine's story in the most appropriate manner.

RECOMMENDATIONS

1. It is recommended that MAGNET be continued with its current broad educational format.
2. It is recommended that our public service and legislative news spot programs be continued.
3. It is recommended that the Communications Committee serve as the focal point and coordinating committee for all other committees in dealing with matters of public interest.
4. It is recommended that the president and president-elect divide the state geographically in an appropriate manner and that they be responsible for making certain visitations to county medical societies and media outlets.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of Recommendation 1, for continuation of MAGNET Conference. Your Reference Committee recommends approval of Recommendation 2, for public service and legislative news programs. Your Reference Committee recommends approval of Recommendation 3, dealing with the coordination of communications efforts.

Your Reference Committee rceommends approval of Recommendation 4, with the following amendment: In the passage, "appropriate manner and that they may be responsible for making certain visitations" . . . your Reference Committee recommends deletion of that section and substitution of the following passage, "appropriate manner, and that they be encouraged to make certain visitations to county medical societies and media outlets." Therefore, the Recommendation would read, "It is recommended that the President and the President-Elect divide the state geographically in an appropriate manner, and that they be encouraged to make certain visitations to county medical societies and media outlets."

HOUSE OF DELEGATES ACTION—Recommendation 1 of the report of the Communications Committee adopted. Recommendation 2 adapted. Recommendation 3 adopted. Recommendation 4 adopted as amended by the Reference Committee.

BIBB COUNTY MEDICAL SOCIETY COUNCILOR

Milton I. Johnson, Jr., M.D.

REFERRED TO:

Ref. Comm. A—Recommendation 3
Ref. Comm. B—Recommendations 1, 2, 4
Ref. Comm. D—Recommendation 5

The Bibb County Medical Society had a most successful year during 1974 under the very able leadership of Dr. W. J. O'Shaughnessey. We have an informed membership concerning the problems faced by physicians in their resistance to socialization of medicine. A continual fusillade of letters from our membership and patients to Washington has been generated. Our Society has worked diligently to aid in the establishment of the Mercer University School of Medicine and has successfully stalled the closure of the venerable Medical Center of Middle Georgia School of Nursing.

RECOMMENDATIONS

1. It is recommended that, when the question comes before the House of Delegates, they continue their strong opposition to participating in the implementation of the so-called PSRO Law. The immediate and ultimate detrimental effects of this law are too well known to merit further detailed discussion. Let the federal government set up their little machine and when it fails, let's not be the goat. Let's refuse to have the Medical Association of Georgia apply for any funds or any designation as a PSRO.
2. Concurrent Hospital Review, Federal Register Vol. 39, No. 231, 11-29-74. Since we have not been able to get any further help from the American Medical Association to fight this unwarranted fiat, it is recommended that the Medical Association of Georgia notify the Secretary of HEW as to our opposition to this regulation. It is further recommended that our legal counsel investigate the feasibility of filing a lawsuit to have this regulation declared illegal. We should also investigate the feasibility of pooling our resources with those of other states and filing a joint suit in this matter.
3. Maximum allowable costs of multiple source drugs, proposed rule listed in the Federal Register Vol. 39, No. 222, 11-15-74. It is recommended that the MAG object to this unwarranted infringement on the practice of medicine for reasons that are obvious to anyone who has read the regulation. The Bibb County Councilor is prepared to present the facts and rational reasons for opposition to same before the reference committee.
4. Amendments to PSRO. We have commitments from many members of our congressional delegation who have introduced bills to repeal PSRO, but we do not know the status of these bills. The most that we

have been able to get out of Senator Talmadge is that he feels that some amendment to this odious law is indicated. It is recommended that we pursue this vigorously and exert pressure to see that amendments are introduced. This approach is not necessarily a schizophrenic attitude on our part because it is an accepted tactic in war to frontally assault your enemy while at the same time one seeks to destroy him from within.

5. Proposed reorganization of MAG Council. While some reorganization of Council is no doubt in order, we are opposed to abolishing the office of Vice Councilor. The Vice Councilor is a valuable member of Council, and it is always well to have someone knowledgeable to Council activities to step in should the Councilor be unavailable or unable to serve.

MEMBERSHIP

County and Secretary	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Bibb				
James B. Lindsay				
Macon	190	172	194	161

(Recommendation 3 of the Bibb County Councilor's report was considered by Reference Committee A.)

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee was asked to review only Recommendation 3, pertaining to maximum allowable costs for drugs. It is recommended that this Recommendation be approved with the following amendment: In the second sentence, it is recommended that all words past "practice of medicine" be stricken from the Recommendation, and the following substitution be made, so that the entire sentence would read, "It is recommended that the MAG object to this unwarranted infringement on the practice of medicine; since the regulations address only cost, with no attention given to patient welfare or quality of the drugs." This would constitute the entire recommendation.

HOUSE OF DELEGATES ACTION—Recommendation 3 of the Bibb County Medical Society Councilor adopted as amended by the Reference Committee.

AMA DELEGATES

J. W. Chambers, M.D.

In its discussions since the AMA Clinical Convention in Portland in December 1974, the Executive Committee has had discussions as to how best to develop information for the MAG House relating to the AMA's present financial situation and the need for the recommended mandatory assessment of $60.00, and the possible subsequent need of a permanent dues increase.

First, to understand the present situation of the AMA financially, it is necessary to go back to 1970 because this is where the basic problem began. At the AMA Annual Convention in June of 1970, I was honored by being selected to serve on Reference Committee F—to study AMA's budget, its financial requirements, and to make recommendations to the House of Delegates. The AMA Board of Trustees reported at that meeting a potential operating deficit of $2 million. In the report it was established by the Board that part of this problem was the result of a 6 to 8 per cent inflationary increase in the cost of operations which had begun as early as 1967 and expanded operational requirements which had been voted by the House of Delegates. These new programs were subsequently estimated by the Board of cost approximately $7.5 million annually beginning in 1971 if they were enacted and put into full operation by the Board of Trustees.

After long and careful consideration by the Reference Committee, which met two days prior to the Chicago meeting, the Reference Committee recommended that ". . . Report B of the Board of Trustees be filed for information." This report recommended an $80 increase in dues. The House subsequently passed a dues increase in the amount of $40 and requested that full and explicit information supporting the need for further dues increases be promptly distributed by the Board of Trustees and constituent state medical associations. This action increased the AMA dues to $110 per year, which is where it has remained.

Each year in the House of Delegates meetings the financial report and the budget of the AMA, as submitted by the Board of Trustees, has been carefully discussed and there has been considerable resistance to any attempt to increase dues during the intervening years through 1974. This, in spite of the fact that the AMA operated at a $2,918,000 deficit finally in 1970, a $973,000 deficit in 1971, a $40,000 profit in 1972, a $1,084,000 deficit in 1973, and a proposed deficit for 1974 of $1,701,000.

At the Portland meeting, the financial affairs of the Association received a third of the total attention of the House of Delegates. It was apparent there was some resistance to increasing dues, and many of the delegates seemed unable to understand why there would be the need for an additional increase of the magnitude which the Board had requested in its report at the annual meeting in 1974. It is significant to add at this point that the Speakers of the House beginning in 1970, had delegated Reference Committee F as the primary finance committee for the House of Delegates, and since that time has been a continuing committee in addition to the Finance Committee, and is the only Reference Committee in the House which is appointed



Cocktails and elaborate hors d'oeuvres draw delegates and their wives to the annual President's Reception Saturday evening.





Representative Larry McDonald, M.D., from the Seventh District of Georgia, is on hand for the President's Reception Saturday and is greeted by outgoing President and Mrs. J. Rhodes Haverty of Atlanta. Auxiliary President Mrs. George Harrison (L) and Mrs. Phil Astin (R), incoming president, talk with Dr. Harrison at the reception.

for a complete year rather than for individual sessions.

As a result of the debate in Portland, a special committee was requested, after the House finally passed a $60 mandatory dues assessment, to study the financial affairs of the AMA in the minutest detail. This committee represented not only Reference Committee F but additional members appointed because of their particular exposure and capabilities. This committee is now meeting and will report to the full House at the June 1975 meeting of AMA in Atlantic City.

After all the discussion before the Reference Committee, it was obvious that additional revenues were needed since the AMA Board was forced to borrow approximately $1,000,000 in order to have operating capital in the months of October, November and December of 1974. Also in the report from the Board, it was established that a rather complete revision of the various structures and other possible economies could be effected without seriously impairing the function of the AMA. The discontinuing of some councils and committees created rather considerable criticism and chagrin to many members of the House, and this was partly responsible for the special study committee which is to report to the House in June of 1975.

To be more specific, the councils which were discontinued and the committees which have just been previously referred to, are the Council on Health Manpower and its Committee on Continued Competence of Physicians, the Committee on Manpower Utilization, the Commission on Emerging Health Manpower, the Council on Mental Health and its committee on Alcoholism and the Committee on Drug Dependence.

In addition, the Committee on Exercise and Physical Fitness, the Committee on Acupuncture, the Advisory Committee on Cancer, the Committee on Cutaneous Health and Cosmetics, the joint Committee on Health Problems and Education of AMA and the National Education Association, the Committee on Hypertension, the Committee on Community Emergency Services, the American Nurses Association, the National League of Nursing Interagency Liaison Committee, the Committee on Nursing, the Committee on Quackery, the Advisory Committee on PSRO. All of the above councils and committees are committees of the Board of Trustees.

Recommended for elimination of the committees appointed by the House of Delegates are: the Advisory Committee on Allied Health Provisions and Services, the Advisory Committee on Continuing Medical Education, the Advisory Committee on Graduate Medical Education, the Advisory Committee on Undergraduate Medical Education, the Committee on Foreign Medical Graduates' Medical Education, the Committee on Private Practice, the Committee on Aging, the Committee on Community Health, the Committee on Government Medical Services, the Committee on Health Care Financing, the Committee on Health Care of the Poor, the AMA National Association of Blue Shield Plans Joint Conference Committee. The elimination of these councils and committees, as previously stated, would not, I believe, necessarily mean that we would no longer have any action in these particular fields. Many of these, I think, can be very effectively referred to other committees or taken over either as partial staff functions of already functioning committees.

For the information of the MAG House, I will include in this material a "White Paper" which has been submitted by the Board, entitled "AMA Council and Committee Structure," released November 11, 1974, which goes into great detail as to how these economies

will be effected and how these functions will be absorbed into other areas which are for those of you who would like to read it at your leisure, rather than incorporating all of this material into this report.

Another of the Board's recommendations was to discontinue accepting advertising for the scientific journals, reduce the number of issues of JAMA, and discontinue the specialty journals. The Board report pointed out several reasons for their recommendations which will be discussed in detail at the Reference Committee hearing.

Finally, may I address what I believe to be necessary to correct the present AMA financial position. As practicing physicians, we are all aware of the increased costs of practice and the various ramifications of inflation in every respect of our everyday lives and in our everyday practices. The AMA is no different from any other organization in that it requires funds with which to function. In my humble estimate, there is no organization in the United States of America which can have more impact on the public, on the Congress or on public opinion than the American Medical Association. Perhaps the AMA could have been more effective, but let us not forget who the AMA is—it is each of us—member and non-member alike. I believe that the greatest problem the AMA has is communicating with its members. I think if I and the other members of our delegation had the personal time to talk with each member of the MAG, either individually or in very small groups, that there would be no problem about keeping them up to date on the activities of the American Medical Association in all that they do, and I doubt that we would have any difficulty in getting these people to pay whatever dues might be required to provide those services. But, as you know, and I know, this is an impossibility, but somehow we must find better means of communicating with not only our membership as it relates to AMA but as it relates to the Medical Association of Georgia as well.

Your AMA delegation has effectively and diligently tried to serve this House and the membership of the Medical Association of Georgia in the past year. It has been for me, and I am sure it has been for them, a pleasure for whatever we have been able to accomplish.

RECOMMENDATION

It is recommended that the House of Delegates of MAG instruct its AMA Delegates to weigh all the issues relative to an increase in AMA dues. The final determination should be based on the necessity of an increase, bearing in mind the continuing need for a strong and unified medical federation.

Addendum
O/C 25-75

November 11, 1974

AMA'S COUNCIL AND COMMITTEE STRUCTURE

During the Board of Trustees' consideration of the 1975 AMA budget, a decision was made to discontinue two councils and 18 committees of the Board and to recommend discontinuance of 11 committees of Councils of the House of Delegates. The Association will continue with 11 councils and 35 committees.

In taking this action, the Board recognized the contributions made by members of the discontinued councils and committees over a long period of time, but the step was necessary in the face of rising costs and the pressures of inflation on all AMA activities.

The discontinuance of a council or a committee does not signify a lessening of Association interest in the corresponding area of activity. To the best of its ability, the AMA will continue the work of the disbanded units through its remaining councils and committees, through its staff, through consultants on an ad hoc basis, and through the use of ad hoc committees where necessary. In keeping with this last comment, the Board has also approved the following recommendation that has emerged from the Long Range Planning process within the last several months:

> "The AMA should be reviewed with a view toward operating with a relatively small number of permanent committees directed toward broad areas of concern. As a particular problem or issue arises which calls for special study, an ad hoc committee should be appointed for that purpose and should be given a specific charge and a specific time frame. These could operate under the auspices of the Board or one of the permanent committees. In addition, AMA should consider the inter-organization advisory committee approach (again on an ad hoc basis) for addressing certain issues as it has done in the case of PSRO."

Following the Board's action, the chairmen of the councils and committees that were affected were informed by telephone and letters announcing the change and expressing thanks for previous work were sent to the members of the bodies that were affected.

The activities of the discontinued units will be maintained as follows:

- The functions of the AMA Advisory Committee on PSRO are to be assumed by the Council on Medical Service and other appropriate units of the AMA as necessary. The Advisory Committee did important work in connection with the early stages of the implementation of the PSRO law, and its activities are an appropriate example of a use of an ad hoc committee to address an important topic during a limited period of time. Staff support will be provided by the Division of Medical Practice.
- The activities of the Council on Health Manpower and its Committees will be assumed by two councils, by several staff units and by the use of consultants when necessary. Activities that relate to manpower use and deployment, the delivery of services by physicians and health related professions, and some aspects of the measurement of continuing competence of physicians will be continued by the Council on Medical Service and the staff of the Division of Medical Practice. Activities that relate to foreign medical graduates and other aspects of the continued competence of physicians will be assumed by the Council on Medical Education and its supporting staff. This Council will also have overall responsibility for the design of

training programs for physicians' assistants and other allied personnel. Both Councils will have substantial assistance from a large number of consultants who have worked with the Council on Health Manpower and the Advisory Committee on Allied Health Professions and Services in the past.

- The activities of the Council on Mental Health and its Committees on Alcoholism and Drug Dependence will be continued by the staff of the Department of Mental Health and consultants on an ad hoc basis.
- The activities of the Committee on Quackery will be assumed by staff with the assistance of consultants and ad hoc committees as needed. The computerization of a large portion of the committee's records will enable the Department of Investigation to continue its activities with a smaller staff complement.
- The activities of the Committee on Nursing will be continued by the Division of Medical Practice, consultants, ad hoc committees, the Council on Medical Service or the Board of Trustees depending upon the nature of the issue under review. The National Joint Practice Commission on Medicine and Nursing, to which the AMA nominates eight of sixteen representatives, will continue its general liaison role between medicine and nursing. The activities of the AMA-American Nurses Association-National League for Nursing Inter-Agency Liaison Committee will be continued by the staff of the Division of Medical Practice, by the Board of Trustees, and by the National Joint Practice Commission.
- The activities of the Committee on Community Emergency Services will be continued by the staff of the Division of Medical Practice, by outside consultants, and by increased participation on the Commission on Emergency Medical Services.
- Committees dealing with cancer, hypertension and acupuncture will be continued by the staff of the Division of Scientific Activities in conjunction with outside consultants. The work of the Committee on Acupuncture was expected to be completed with the development of a policy statement in early 1975. The Department of Health Education will be directly involved with continuing some activities of the Committee on Hypertension. Ad hoc committees will be created to deal with other disease entities as necessary.
- The activities of the Committee on Exercise and Physical Fitness will be continued by the Department of Health Education and by the use of outside consultants, as will the activities of the Joint Committee on Health Problems in Education of the AMA and the National Education Association.
- The activities of the Committee on Cutaneous Health and Cosmetics will be continued by the staff of the Division of Scientific Activities and consultants as needed.

The following summarizes the distribution of the activities of committees of the Councils on Medical Service and Medical Education:

- With regard to the Council on Medical Education, the activities of advisory committees dealing with allied health personnel, continuing medical education, graduate medical education, and undergraduate medical education will be assumed by the Council itself. A substantial number of knowledgeable consultants in each of these areas of interest is available to assist the Council with its deliberations. Ad hoc committees can be created to deal with specific problems as necessary. Staff support is available from the Departments of Allied Medical Professions and Services, Continuing Medical Education, Graduate Medical Education and Undergraduate Medical Education.

- With regard to the Council on Medical Service, the Council will assume the responsibility of the committees dealing with health care financing, aging, private practice, health care of the poor, community health, and government medical services. A substantial number of consultants are available to the Council, and the staff structure of the Division of Medical Practice continues without major revisions.
- The liaison activities of the Joint Conference Committee of AMA and Blue Shield and the Joint Liaison Committee of the AMA-American Association of Medical Clinics-Medical Group Management Association will be assumed by the Council on Medical Service and the staff of the Division of Medical Practice.

During its deliberations, the Board of Trustees also agreed to reduce the size of the AMA staff from the present 997 to a complement of 950. This reduction will largely be achieved in staff units other than those assigned to the councils and committees listed above. In some instances, the computerization of records, and the development of new procedures will allow some reduction in the staff of the units referred to in this document.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report with highest commendation, and would invite the special attention of this House of Delegates to the followng passage from the report: "Finally, may I address what I believe to be necessary to correct the present AMA financial position. As practicing physicians, we are all aware of the increased costs of practice and the various ramifications of inflation in every respect of our everyday lives and in our everyday practices. The AMA is no different from any other organization in that it requires funds with which to function. In my humble estimate, there is no organization in the United States of America which can have more impact on the public, on the Congress or on public opinion than the American Medical Association. Perhaps the AMA could have been more effective, but let us not forget who the AMA is—it is each of us—member and nonmember alike. I believe that the greatest problem the AMA has is communicating with its members. I think if I and the other members of our delegation had the personal time to talk with each member of the MAG, either individually or in very small groups, that there would be no problem about keeping them up to date on the activities of the American Medical As-

sociation in all that they do, and I doubt that we would have any difficulty in getting these people to pay whatever dues might be required to provide those services. But, as you know, and I know, this is an impossibility, but somehow we must find better means of communicating with not only our membership as it relates to AMA but as it relates to the Medical Association of Georgia as well."

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA Delegates.

RESOLUTION 15-75

CENTRAL STATE HOSPITAL STUDY

E. W. Allen, M.D., Delegate,
Baldwin County Medical Society

WHEREAS, it is recognized that conditions at Central State Hospital and in other institutions operated by the Department of Human Resources have deteriorated to the point that morale of the professional staff, i.e., physicians, has reached such a low ebb that numerous members are finding it necessary to resign. This deplorable condition has resulted from certain policies that have been instituted by the Department of Human Resources over the past several years. There has been a sublimation of the role of the physician, and the decision making concerning patient care is being carried out by nonmedical persons, therefore be it

RESOLVED that MAG is opposed to this deplorable situation, and that this Association requests the appointment of a blue ribbon committee to study this problem in depth and to make recommendations to the Governor so that he may take proper action.

THEREFORE, BE IT RESOLVED that the President of the Medical Association of Georgia and the President of the Baldwin County Medical Society hand deliver a copy of this resolution to Governor Busbee, the Director of the Division of Mental Health of the Department of Human Resources, the Chairman of the Board of Human Resources, and to present this resolution to the Board of Human Resources.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends the acceptance of the "Whereas" portion of this resolution and further recommends the disapproval of the two resolved portions of the Resolution, and would offer the following substitution, "Resolved that MAG be on record as opposing any situation that would detract from the physician's traditional role as the person primarily responsible for delivering the medical care of patients in state institutions; and be it further resolved that MAG support the concept of no person other than a physician being responsible for patient care and; Resolved that MAG Council be directed to appoint a blue ribbon committee to study problems that exist in the state institutions, and that this Committee should report back to the MAG Council, and; Be it further resolved that after MAG Council review and approval of the report, that an appropriate copy of the study be transmitted to the Governor of the State of Georgia.

HOUSE OF DELEGATES ACTION—Delegate Robert E. Wells moved that the report of the Reference Committee be amended by inserting the word "medical" between the words "patient" and "care" in the first "Resolved," and that the word "medical" be inserted between the words "study" and "problems" in the second "Resolved." A second was received and the amendment was adopted.

The House then adopted Resolution 15-75 as amended by the Reference Committee and as additionally amended on the floor of the House.

Chairman Oliver expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Reference Committee report be adopted as a whole as amended. This motion was duly seconded and approved.



Reference Committee B

REPORT OF REFERENCE COMMITTEE B

WILLIAM C. WATERS, III, M.D., Chairman

Chairman Waters reported to the House of Delegates that the reports and resolutions referred to Reference Committee B had been considered by the committee which met at 1:30 p.m. in the Izmir Room, Fairmont Colony Square Hotel, Atlanta, Georgia, on April 18, 1975. Members of the committee present included William C. Waters, III, M.D., Atlanta, Chairman; Jack A. Raines, M.D., Columbus, Vice Chairman; John G. Bates, M.D., Cuthbert; Roy Vandiver, M.D., Decatur; Harry Porter, Jr., M.D., Smyrna; and Thomas N. Lumsden. M.D., Clarkesville.

GEORGIA MEDICAL CARE FOUNDATION

C. E. Bohler, M.D.

The Georgia Medical Care Foundation is nearing the end of another year of development and growth serving the physicians of Georgia. Through the use of an incoming WATS line, the Foundation's staff has been

able to assist many of you in obtaining payment for claims with which there have been problems, or at least to put you in contact with someone who could explain to you why you received what you did.

The Nursing Home Review Program continues to operate successfully, seeing over 20,000 patients per year and involving more than two dozen private-practicing physicians in day-to-day evaluation of the needs of the state's nursing home patients.

The contract with the Georgia Department of Human Resources was again renewed for the current fiscal year, and again the review of physician and hospital claims continue to flow at the same volume. An addition to this Medicaid function is the implementation of the CHEC Pilot Program. Thanks to a joint grant/loan by the Department of Human Resources and the Medical Association of Georgia, the Foundation in January began operating the CHEC Pilot Program in four hospital in Georgia to demonstrate the ability of organized medicine responsibly and effectively to monitor and account for the medical care delivered in Georgia. As this report is being written, the program is working well and has elicited a great deal of interest in the medical and hospital communities.

Related to the implementation of the CHEC Pilot Program are the joint talks on concurrent hospital utilization review conducted with the Georgia Hospital Association, Blue Cross of Columbus and Atlanta, and the Medical Association of Georgia. Dr. Haverty has reported on these talks in more detail elsewhere, and I would urge you to consider carefully the full impact of the tremendous amount of work that has been done in this area.

RECOMMENDATION

1. I would recommend that the House of Delegates give its whole-hearted support and endorsement to the implementation of the CHEC Program on a state-wide basis as soon as possible.

REFERENCE COMMITTEE RECOMMENDATION —Reference Committee B considered at some length the activities of the Georgia Medical Care Foundation—specifically, the concurrent hospital review program, CHEC. Additional detailed information on the Foundation and the CHEC Program was made available to the committee in the comprehensive report submitted by Dr. McCain and considered below. In discussing the recommendation contained in the Foundation Report requesting support and endorsement for the implementation of the CHEC Program on a state-wide basis, your Reference Committee concluded that MAG should, indeed, encourage the expansion of the CHEC Program to all Georgia hospitals and to cover all patients. In so doing, however, your committee wishes that the Foundation's expansion of the CHEC Program be related to the willingness of hospitals and third-party carriers to pay for this program, as has been done by the Georgia Legislature for the Medicaid Program.

Therefore, your committee suggests that Recommendation 1 be amended to read:

"1. The Medical Association of Georgia House of Delegates gives its whole-hearted endorsement to the implementation of CHEC for the Medicaid Program on a state-wide basis as soon as possible and for other government and private prorams when similar funding is made available by them."

Mr. Speaker, your committee recommends that Recommendation 1 be approved as amended.

HOUSE OF DELEGATE ACTION—Adopted the report of the Georgia Medical Care Foundation as amended by the Reference Committee.

AD HOC COMMITTEE TO EVALUATE PEER REVIEW MECHANISMS

John R. McCain, M.D., Chairman

The 1974 MAG House of Delegates adopted the report of Reference Committee C which included a recommendation that a special force be appointed to subject to intensive scrutiny peer review mechanisms such as the Georgia Medical Care Foundation's CHEC Program and to report back on its findings to the next annual meeting of the House of Delegates.

The MAG Executive Committee appointed the Ad Hoc Committee to Evaluate Peer Review Mechanisms to undertake this task. This ad hoc committee has met on two occasions and has spent considerable time in studying a variety of peer review mechanisms currently functioning or available in the state.

During the first meeting of the committee, the members had an opportunity to listen to presentations made by the Metropolitan Atlanta Foundation for Medical Care on its peer review programs primarily on the subcontract from the state foundation for Medicaid claims' review. Additionally, the Atlanta Foundation presented its peer review appeals procedure. The current review structure at the Atlanta Foundation includes: 1) screening of claims by a nurse; 2) referral of problem claims to a foundation consultant; 3) consideration of questionable claims by a specialty panel; 4) referral of particularly difficult claim questions to the Foundation Peer Review Committee; 5) appeals from decisions by lower review bodies to the Medical Association of Atlanta Peer Review Appeals Committee; 6) final appeals referred to the MAG Peer Review Committee.

A presentation was also made by the Georgia Medical Care Foundation on its review activities. As described by the state foundation, the review activities functioning at the state level were similar to those at the Metro Atlanta Foundation: 1) Screening of claims by a nurse; 2) referral to a physician consultant when necessary; 3) consideration by a specialty panel when appropriate; 4) personal appeal to a specialty panel; 5) final appeal to the MAG Peer Review Committee.

Considerable time was spent during the first meeting of the committee on the Georgia Foundation's CHEC (Certified Hospital Extension of Care) Program. The CHEC Program is in essence a procedure for certifying the medical necessity of admissions and approving the necessity of continued hospitalization. The CHEC Program utilizes criteria developed at the state level and adapted to local conditions by the individual hospital medical staff participating in the CHEC Program. The criteria are used for screening purposes by the Utilization Review Coordinators who provide the initial review of patient admissions and make determinations concerning the necessity of referring continued stay cases to a UR consultant. An appeals process through

the UR Committee, Regional CHEC Committees, state specialty panels, and the MAG Peer Review Committee are available in situations where the attending physician is not satisfied with an action taken by a lower review body.

Other programs reviewed by the ad hoc committee included the JCAH's PEP (Professional Evaluation Procedure) Program which functions as a medical audit system based on a concept of exception reporting for diagnoses and procedures based on criteria set by the individual hospital medical audit committee.

The MAG R&D Department's Information for Medical Audit through Generation of Exceptions (IMAGE) Program (this program has been replaced by the MCE Program described below) was also considered by the committee including the development of criteria for diagnoses and procedures which were being developed in concert with the state specialty societies. Considerable discussion took place on the need for a data collection system to collect abstracts completed on each hospitalized patient in order to provide information for the purposes of medical audit and concurrent review.

At this initial meeting of the committee, it was pointed out that the MAG and five other organizations had come together to form an Ad Hoc Committee on Concurrent Hospital Review. This group included representatives of the Georgia Hospital Association, the Georgia Medical Care Foundation, the Metropolitan Atlanta Foundation for Medical Care, the Blue Cross of Columbus, and the Blue Cross of Atlanta. These groups were brought together by the MAG in order to consider the possibility of developing a uniform concurrent hospital review system which would function throughout the state for both Medicaid and Medicare. At the conclusion of the first meeting of the Ad Hoc Committee to Evaluate Peer Review Mechanisms it was determined that a subsequent meeting would not be held until some results had been reported from the Ad Hoc Committee on Concurrent Hospital Review.

At the last meeting of the Ad Hoc Committee to Evaluate Peer Review Mechanisms, the committee discussed the details of the review mechanism in the Foundation's CHEC Program, MAG R&D Department's Medical Care Evaluation (MCE), the Metro Atlanta Foundation's review mechanism, the Medical Association of Atlanta's appeals system, and the MAG Peer Review Committee. Each of these agencies or organizations submitted to report on their role or functioning in a peer review system for Georgia. The following are the reports from those agencies, organizations or committees.

GEORGIA MEDICAL CARE FOUNDATION

The Georgia Medical Care Foundation was established by the Medical Association of Georgia in 1970, among other reasons, to function as the peer review arm of organized medicine in the state of Georgia. Through contracts with various intermediaries, the responsibility for determining the medical appropriateness of services delivered under various health care reimbursement programs has increasingly come under the wings of organized medicine, and the Foundation is currently responsible for reviewing hospital, physician, and nursing home services delivered under the Medicaid program, physician services delivered under the Blue Shield/Atlanta program, services delivered under CHAMPUS, as well as services delivered by a great number of private insurance companies and Medicare-Part B.

The Foundation has recently begun the implementation of a state-wide concurrent hospital utilization and admission review program called CHEC (Certified Hospital Extension of Care). This program is being implemented under the specific mandate of the Medical Association of Georgia and under the direction of the Board of Directors of the Georgia Medical Care Foundation, and will immediately be responsible for the concurrent review of all admissions taking place under the Medicaid program as well as admissions taking place under the Medicare program in approximately 20 hospitals. Under the terms of the agreement reached with the Blue Cross organizations in Georgia, the Georgia Hospital Association, the Medical Association of Georgia, and the Metro Atlanta Foundation, the responsibility for review of the remainder of the Medicare admissions, as well as those of private Blue Cross patients and private health insurance companies, patients will become the responsibility of the Foundation over the coming year. It should be noted here that while the CHEC Program is not a PSRO at this time, its operation and mechanism conform very closely with the requirements of the utilization review regulations of November 29, 1974, and the PSRO regulations as we know them at this time. Moreover, through close cooperation with the Research and Development Branch of the Medical Association of Georgia, the Foundation and the CHEC Program are acquiring the medical audit and data processing capabilities necessary in order to fulfill the third aspect of the review regulations in acute general hospitals.

The Health Insurance Association of America has indicated a sincere interest in seeing responsibility for concurrent review of private paid patients assumed in the name of organized medicine by the Georgia Medical Care Foundation in the near future, and has been most cooperative and encouraging in its relationship with us.

All of this has been by way of background. The question before us is where does the Foundation fit in the peer review mechanism in the state of Georgia in the coming year. A satisfactory answer can be given.

PSRO, while not here now, will be upon us shortly. The Georgia Medical Care Foundation cannot, at this time, be the PSRO in Georgia due to the format of its current bylaws. It is, however, the one organization in the state most capable of satisfying the requirements of PSRO designation in the shortest time possible and with the least amount of disruption of the practice of medicine in Georgia. It would seem logical, therefore, that the Georgia Medical Care Foundation be the organization in Georgia responsible for the conduct of peer review throughout the state, and that PSRO of Georgia, when it becomes active, contract with the Georgia Medical Care Foundation for the performance of the functions required under the PSRO law. This would allow PSROG to take full advantage of the skills and expertise already extant within the Foundation functions; it would allow the Foundation to continue to develop its expertise in other areas to which the PSRO laws and regulations do not address themselves at this time—specifically private paying hospital patients, ambulatory services, and nursing home utiliza-

tion review; it would have the added benefit of assuring that as great a number of private practicing physicians as possible remain involved in the operational and policy setting aspects of peer review in Georgia through service on the Foundation's Board of Directors as well as on the PSROG Board of Directors; and it would eliminate the need to duplicate an established and accepted peer review mechanism already operating in the state of Georgia.

MAG'S MCE DATA SYSTEM

The MCE data system developed by MAG's Research and Development staff will be operational July 1975 in Georgia hospitals. A hospital discharge abstract system producing the traditional medical records indexes and administrative reports, MCE has two significant additional features: 1) compatibility with CHEC data requirements, and 2) a medical audit report in the JCAH format.

1. It would normally be necessary for hospitals to abstract information twice on a large number of its discharges—once for the CHEC Program, and once for the hospital's abstract system. As MAG will be under contract to process CHEC data for the Foundation, much of the medical information required by the MCE abstract system will already be in MAG's computer, making it unnecessary for the hospital to abstract that data again—thereby saving time and money.

2. The MCE data system generates a medical audit report utilizing criteria developed by the hospital in the format specified by the Joint Commission on Accreditation of Hospitals. These criteria are printed in the narrative on the medical audit report, and the various mathematical calculations shown.

This report provides room for the review comments of the hospital audit committee, and—when completed—is in the form of the documentation required by JCAH. JCAH has expressed particular interest in our data system as a means of assisting hospitals in the performance of MCE studies. Blue Cross Atlanta and Blue Cross Columbus have also expressed interest in helping us market the MCE data system in Georgia hospitals. JCAH and Blue Cross interest—if formalized into endorsements or agreements—will insure the widespread use of the MCE data system. As part of our service to hospitals, JCAH outcome criteria developed by Georgia's specialty societies are being distributed as guides to the development of individual hospital medical audit criteria.

It is expected that the MCE data system will incorporate and replace the CHEC data system January 1, 1976 and that it thus will be in use by all Georgia hospitals for patients undergoing concurrent review (of any type). It is further expected that the great majority of Georgia hospitals will be utilizing the MCE data system for generation of indexes, reports, and medical care evaluation studies by January 1, 1976 as well.

The relationship of the MCE data system to medical review in Georgia will be well-established by January of 1976. With continued input from the specialty societies and feedback from the hospitals' medical audit committees, the staff of MAG's MCE data system will be able to assist hospital staffs improve their review techniques by taking advantage of review criteria, methods, and approaches already developed. Physician organizations charged with review responsibilities—such as the Foundations for Medical Care—will also benefit from the existence of aggregated state-wide data on medical practice as they seek to identify problem areas so as to establish review priorities in accordance with need.

METROPOLITAN ATLANTA FOUNDATION FOR MEDICAL CARE, INC.

The Metropolitan Atlanta Foundation for Medical Care is an organization of practicing physicians encompassing an eight county area. This area includes the counties of Fulton, Cobb, Paulding, Clayton, Fayette, Carroll, Douglas, and Haralson. Our organization has been involved in peer review activities for a number of years and has in place a functioning staff with appropriate back up physician consultation capable of cooperating within the framework of a state-wide Peer Review Program.

Inasmuch as we are a local organization and our physicians are on most if not all hospital staffs, we have the further capability of working closely with hospital staffs and their UR committees.

A basic premise of the Metropolitan Atlanta Foundation for Medical Care is that peer review is best accomplished at the local level utilizing local physicians and hospitals consistent with their capabilities and objectivity.

Within our local Foundation review structure the Peer Review Committee is the final recommending authority and has the responsibility of overseeing the review program. The Peer Review Committee is representative of most, if not all specialties and approves policies and guidelines recommended by the various specialty panels. It is felt this mechanism precludes any one specialty from complete control without total medical overview.

It is felt that the state organization should be responsible for coordination of data standardization and processing with support to local organizations incapable or unwilling to do peer review.

MEDICAL ASSOCIATION OF ATLANTA

The Medical Association of Atlanta has been involved in "claims review" since 1964-65 and has been doing so-called peer review since 1970.

The basic elements of peer review in the last four years have been carried out by our subsidiary, the Metropolitan Atlanta Foundation for Medical Care.

The Medical Association of Atlanta does function in the areas of appeals and continuing education.

After all the various levels of review have been completed in the Foundation, a physician or third party or patient may appeal to the Peer Review Appeals Committee which is chaired by a representative of MAA and consists of representatives nominated by each Specialty and appointed by the President of MAA. This committee acts as the final appellate group at the county society level.

Any further appeal would go from this committee to the MAG Peer Review Committee.

In addition, the MAA maintains a vital interest in continuing education of physicians through its regular association meetings and its annual four-day postgraduate meeting, the Atlanta Graduate Medical Assembly.

MAG PEER REVIEW COMMITTEE

The Peer Review Committee of MAG will provide:

A. The development of *medical policy* for review as described below.
   1. The preparation of a Policy Manual for Medical Care Review.
   2. It is anticipated that the Policy Manual for Medical Review will be published by the Georgia Foundation.

B. The Peer Review of claims:
   1. Appeal from the Specialty Panel decisions.
   2. As requested by the Foundation Board.
   3. Upon appeal from a regional review organization.
   4. Upon direct appeal by the physician, hospital or patient.

   The review mechanism of the Peer Review Committee will utilize the patterns of practice primarily, not the review of individual claims.

   The results of the recommendations and of the decisions of the Peer Review Committee will be reported to the Foundation Board.

   If the original decisions or recommendations of the Consultant or of the Specialty Panel are modified by later review, the Consultant, or the Consultant and Panel, will be notified. The reasons for the change will be provided. The Foundation is to be responsible for the transmission of this information.

C. The Peer Review Committee will have as one of its responsibilities the identification of *educational needs* as demonstrated by the review process.

   The Peer Review Committee will notify the Committee on Education of its findings. It will cooperate with the Committee on Education in any way which may be desired to develop satisfactory programs of education.

I. Organization
   A. Members are currently organized for MAG.
      1. Appointments to committee recommended by the Specialty Societies and confirmed by MAG Council.
   B. Foundation Board Member
   C. Foundation Staff Representation—non-voting

II. Function
   A. Policy
      1. Develop medical policies for medical care review (subject to the approval of Foundation Board and of Council).
      2. Prepare (or supervise the preparation of) Policy Manuals for Medical Care Review.
   B. Peer Review
      1. As requested by the Foundation Board.
      2. The multi-specialty peer review of appeals or referrals from decisions of Specialty Panels.
      3. The claims appealed from decisions of medical consultants of third party carriers would be referred to Specialty Panels—not initially to the Peer Review Committee.
      4. Patterns of practice to be the essential basis of this review, not individual claims.
   C. Responsibility
      1. Report to Foundation Board results of all peer review decisions or recommendations, and statement of reasons for any changes that have been advised.
   D. Education
      1. Identify educational needs as demonstrated by peer review.

AD HOC COMMITTEE ON CONCURRENT HOSPITAL REVIEW

The Subcommittee of Six which is part of the Ad Hoc Committee on Concurrent Hospital Review has recommended to their parent organizations a proposal for the conducting of concurrent hospital review in Georgia. This proposal has been adopted by each parent organization including the MAG Council. The basic elements agreed upon by the six organizations—MAG, GMCF, MAFMC, GHA, Blue Cross of Atlanta, and Blue Cross of Columbus—are as follows:

I. The Georgia Medical Care Foundation together with its subcontractors should be the agencies in the state of Georgia responsible for the conduct of concurrent hospital utilization review programs.

II. Affiliated with the Board of Directors of the Foundation should be an Advisory Committee to consist of one representative of each of the following organizations: Blue Cross of Atlanta, Blue Cross of Columbus, the State Medicaid agency, the Health Insurance Association of America, The Georgia Hospital Association, the Medical Association of Georgia, the Georgia Medical Care Foundation, an ex-officio representative of the Metropolitan Atlanta Foundation for Medical Care, and a representative of the public—possibly the Insurance Commissioner.

III. The Advisory Committee would review policy and present comments to the Foundation Board in areas of both administration and operations. The Advisory Committee would also perform liaison activities with the Board of Directors, the various carriers and intermediaries, hospitals, and the public. Possible new areas of program development would also be within the purview of this committee. The committee would be responsible for advising the Foundation and its Board of Directors of the interests of those whom they represented, as well as assuring the accountability of the Foundation's concurrent review activities to the payors, the public, and the hospitals. Within this context, regular reports would be made to, and audits performed by, members of the Advisory Committee with regard to the timeliness of review conducted under the program, and the appropriateness of expenditures for such review under the program. Moreover, a certain amount of attention would be paid to the efficacy of the medical review itself, with possibly some audits being conducted to assure that the Foundation was following established criteria for medical review. The Foundation would have the responsibility and authority to spot check the performance of the utilization review committees within individual facilities. The various intermediaries and carriers would provide assurance to the Foundation that all claims exceeding jointly developed screens were in fact being forwarded to the Foundation for further review.

IV. A proposed phase-in schedule for the various

health insurance programs to be incorporated into this concurrent review system: Medicaid, April 1-July 1, 1975; Blue Cross Medicare, July 1, 1975; Other elements of the health insurance field, July 1, 1975 to January 1, 1976.

V. A concurrent and retrospective review flow chart have been developed. It should be noted that in the development of this program, the proposed concurrent review system model was prepared to be consistent with requirements being established by the Federal government for the operation of a PSRO.

In Summary: 1) The Georgia Medical Care Foundation and its subcontractors such as the Metro Atlanta Foundation should be the agencies responsible for the conduct of concurrent hospital review in Georgia as outlined in the CHEC Program; 2) the Georgia Foundation would have an Advisory Committee with representatives from the various payors, the public and the Atlanta Foundation, which would function in an advisory capacity concerning the concurrent hospital review system; 3) the various payors would, should they wish, be responsible for Level 1 review, i.e., the screening of claims submitted against criteria and parameters established and agreed to by the intermediary and the Foundations; 4) the Foundations would be totally responsible for Level 2 and Level 3 review, i.e., the nurse reviewer and the physician in all levels of physician review.

MODEL PEER REVIEW SYSTEM

In considering these various aspects and components of the peer review, the committee was reviewed and discussed a suggested outline for a model peer review system for the state. This outline served as a brief description of how the review system might function at the local, regional and state levels as well as the procedure of appeals.

I. Local Review Activities
   - A. Utilization review by committees of hospitals and nursing homes as required by HEW regulations.
   - B. Where staffs are too small, unable or unwilling to perform utilization review use of
     1. A committee with representation from several facilities.
     2. Outside review done by hired consultant or
     3. Centralized review by a regional or state review agency.
   - C. Medical audit performed pursuant to applicable regulations.

II. Regional Review Activities
   (If a regional organization exists and is a subcontractor of the state review organization.)
   - A. Evaluation of hospital UR functions in its region—timeliness, efficiency, objectivity.
     1. Analysis of data—physician and patient profiles—generated by the concurrent hospital review program.
     2. Review of criteria, standards and norms used by hospitals and nursing homes for UR.
   - B. Evaluation of hospital and nursing home medical audit activity in its area.
   - C. On site professional and independent review of nursing home patients.
   - D. Pre-admission certification of nursing home admissions.
   - E. Retrospective review of in-patient, out-patient and office services provided by physicians.

III. State Review Activities
   - A. Overall supervision and responsibility for operation of a concurrent admission and UR program.
     1. Where regional review organizations are functioning, evaluation of their activities.
     2. In regions without review organizations, direct evaluation of programs.
   - B. Evaluation of hospital and nursing home medical audit activities for state and regions (as in A above).
   - C. On site Professional and Independent Review of nursing home patients for state and region (as in A above).
   - D. Pre-admission certification of nursing home admissions for state and region (as in A above).
   - E. Retrospective review of in-patient, out-patient and office services provided by physicians (as in A above).
   - F. Analysis of data—physician and patient profiles—generated by concurrent hospital review program for state and regions (as in A above).
   - G. Review of criteria, standards and norms used by hospitals and nursing homes for UR for state and region (as in A above).
   - H. Retrospective verification of decisions of concurrent admission and utilization review activities of all hospitals.

IV. Appeals of Review Decisions
   - A. From local review decisions to
     1. regional appeals body (if one exists), or
     2. state appeals body
   - B. From regional review decisions to regional appeals body, then
   - C. From regional appeals body to state appeals body
   - D. Final appeal consideration—MAG Council

Based on its comprehensive review of peer review mechanisms available in Georgia, the Ad Hoc Committee to Evaluate Peer Review Mechanisms wishes to make the following recommendations to the House of Delegates:

RECOMMENDATION 1:

The committee recommends that the mechanisms for peer review in Georgia coordinate their activities according to the following relationships:

I. *Georgia Medical Care Foundation:*
   - A. The Georgia Medical Care Foundation has the primary responsibilities for the operational aspects of the Peer Review Program in Georgia.
     1. The concurrent hospital review aspects of peer review are to be developed through the Certified Hospital Extension of Care (CHEC) Program.
     2. The retrospective peer review for the evaluation of the quality of hospital care is also to be developed through the CHEC Program.

II. *Peer Review Committee of the Medical Association of Georgia:*

A. The Peer Review Committee of MAG is the appellate mechanism for the Medical Care Foundations in Georgia.

1. The review by the Peer Review Committee is to be primarily that of "patterns of practice," not the review of individual claims.
2. Individual claims can be appealed directly to the Peer Review Committee outside of the review mechanism of the Foundations.

B. The responsibilities of the committee include the development of policies relating to peer review, subject to approval by Council.

C. The committee should develop programs involving the educational aspects of peer review. Such programs should be developed in cooperation with other appropriate committees of MAG.

III. *The CHEC Program:*

A. The CHEC Program has been developed by the mutual agreement of:

The Medical Association of Georgia
The Georgia Medical Care Foundation
The Metropolitan Atlanta Foundation for Medical Care
The Georgia Hospital Association
The Blue Cross of Georgia/Atlanta, Inc.
The Blue Cross of Georgia/Columbus, Inc.

The CHEC Program is the mechanism for coordinating the activities of the Utilization Review Committees of the hospitals in Georgia.

1. By means of the CHEC Program problems encountered by the Utilization Review Committees regarding peer review can obtain peer consultation on a concurrent basis.

IV. *Regional Foundations (The Metropolitan Atlanta Foundation for Medical Care):*

A. The Georgia Medical Care Foundation for state-wide programs of medical care may develop subcontracts with a regional Foundation for the review of the activities of the state-wide program within the geographic area served by the Regional Foundation.

B. Regional Foundations may develop local or regional programs of medical care with each Foundation utilizing its own review mechanism for such services.

RECOMMENDATION 2:

The Ad Hoc Committee to Evaluate Peer Review Mechanisms in Georgia strongly endorses the Medical Care Evaluation (MCE) Program, currently being developed by the Medical Association of Georgia, for use by physicians and by hospitals in Georgia.

RECOMMENDATION 3:

The evaluation of the peer review of medical services in Georgia reveals that a few physicians are providing inadequate and/or inappropriate care for their patients.

The Ad Hoc Committee recommends that the House of Delegates designate, or appoint, an appropriate committee or organization to develop a satisfactory mechanism for the solution of this problem.

REFERENCE COMMITTEE RECOMMENDATION—It was with great pleasure that your Reference Committee reviewed this very exhaustive report presented by Dr. McCain's committee which was created last year at the request of the House. Our only regret was that more time could not have been devoted to a consideration of the intricacies in the relationships among peer review mechanisms explicated by this comprehensive report.

In considering Recommendation 1, the mechanisms for peer review in Georgia, it was brought to the attention of your committee that clarification was required of one element of this description, in that the CHEC program applies primarily to length of stay rather than overall quality of care.

Your Reference Committee suggests that Recommendation 1, Section I, paragraph A, sub-paragraph 2 dealing with retrospective peer review be amended so that it would read:

"(2) The valuation of concurrent hospital review is also to be developed through the CHEC program."

Mr. Speaker, your committee recommends that Recommendation 1 be approved as amended.

Recommendation 2 of this report reflects a thorough review of the Medical Association of Georgia's Research and Development Department's development of an automated system of medical audit—MCE, the Medical Care Evaluation Program. This program was also discussed by your Reference Committee during its consideration of the report from the EMCRO Committee.

Recommendation 2 calls for endorsement of MCE which was described to your committee as one of the most outstanding systems for performance of medical audit to be found in the nation.

Mr. Speaker, your committee recommends adoption of Recommendation 2.

Although your Reference Committee was in complete agreement with the concern expressed by Recommendation 3, the committee felt that our concern for patients who were being provided inadequate or inappropriate care by a very few physicians in our state could be more clearly expressed in the following terms:

"Peer review mechanisms occasionally identify physicians whose activities consistently depart from the usual experience of their colleagues. Repeated correspondence between the review mechanism and the physicians in question fails at times to reconcile this difference of opinon. In order to offer some guidance to the various peer review mechanisms—such as foundations, peer review, medical audit, utilization review and similar committees—the Medical Association of Georgia House of Delegates specifically recommends and requests that the peer review mechanisms communicate the nature of the dilemma to the ethics committee of the physician's county medical society and to the ethics committee of the physician's specialty society, where applicable. Furthermore, should these efforts fail to successfully resolve the issue, the peer review mechanism is urged to refer the matter to the Medical Association of Georgia Peer Review Committee for further appropriate action."

Mr. Speaker, your Committee recommends that this substitute recommendation be approved in lieu of Recommendation 3.

Your Reference Committee wishes particularly to commend Dr. McCain and the members of the Ad Hoc Committee for the diligence and perceptiveness with which they discharged their task and executed their report on peer review mechanisms.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ad Hoc Committee to Evaluate Peer Review Mechanisms as amended by the Reference Committee.

EMCRO COMMITTEE

Ollie O. McGahee, Jr., M.D.

During the past year, MAG has worked individually with 15 hospitals in Georgia to develop medical audit programs in those hospitals in order to meet JCAH medical audit requirements. This activity is funded by the Georgia Regional Medical Program and is given a high priority by GRMP for continued funding into 1976. This project, directed by Sybil Wells, has been well received by the Georgia Hospital Association, as well as by individual hospitals. JCAH recognition of the activity is being sought. Beginning in the summer of 1975, the project will expand its activities to meet the needs of a larger number of hospitals by conducting medical care evaluation workshops for physicians and medical audit committee assistants. The purpose of the workshops will be to assist these hospital representatives in implementing a medical audit program in their own hospital which will meet JCAH requirements. The EMCRO Committee feels that this activity is an extremely valuable one that should be continued, and that project staff deserves congratulations for a difficult job well done.

The EMCRO Committee has guided MAG's development of a new hospital discharge abstract system, MCE (Medical Care Evaluation), this past year. The medical audit portion of the data system has already undergone testing in two Georgia hospitals, with more testing to follow this spring. In the summer, the entire data system will be field-tested in order to establish run times and costs (estimated at 50¢ per discharge). MCE will be marketed throughout Georgia in the fall, and fully operational by the January 1, 1976, start-up date.

MCE produces the medical records indexes and administrative reports required of any hospital discharge abstract system, but it has two significant additional features:

1. A medical audit report in the JCAH format, and
2. Adaptability to CHEC data requirements.

The medical audit report is in a streamlined JCAH format, with hospital-developed criteria displayed in the narrative. Variations are aggregated and arrayed in the report and computations performed as required by JCAH. The medical audit report provides space for the committee assistants' and physician reviewers' comments, allowing the report itself to serve as the JCAH-required documentation. MAG will provide instructions and sample criteria in JCAH format for hospital use in criteria development. MAG's medical care evaluation workshops referenced above as well as other medical audit workshops more limited in nature will be available to assist medical staffs in the effective use of MCE's medical audit capability.

The data system is also adaptable to the concurrent review data requirements of the Georgia Medical Care Foundation's CHEC program. These data requirements will be incorporated in the MCE data system in advance of the January 1, 1976 start-up date. Use of MCE's concurrent review component will be a no-cost option for participating hospitals who wish to take advantage of the opportunity to complete a single abstract for one multipurpose data system as opposed to two abstracts for two independent data systems. (Hospitals not utilizing the MCE concurrent review option will complete a separate abstract for the Georgia Medical Care Foundation.)

No other such multipurpose data system exists in the country, and such flexibility and responsiveness on the part of this MAG-directed and operated data system will enable MCE to continue to adapt as needed to the changing data needs of Georgia hospitals and physicians. The EMCRO Committee feels very strongly that MCE is the data system most able to assist in JCAH review and that the multipurpose data system concept embodied in MCE will prove to greatly reduce costs associated with increasingly duplicatory demands for data collection within hospitals. The EMCRO Committee considers MAG's development of MCE to be an extremely significant accomplishment.

RECOMMENDATIONS

1. That MAG assume a responsibility for aiding physicians in the development of effective medical care evaluation programs at the level at which they are most effective—the level of the medical staff—and that these programs include development and distribution of sample criteria and the conduct of medical care evaluation workshops for physicians and committee assistants.
2. That the MCE data system be endorsed by MAG and recommended for use by medical staffs and hospitals as it is the data system most effective in aiding in the conduct of JCAH-required medical audit studies, and most able to respond to the multiple data needs of Georgia physicians and hospitals.
3. That the EMCRO Committee be continued as the Committee on Medical Care Evaluation Systems with a responsibility for overseeing the development of effective medical care evaluation programs and related data systems.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee heard several speakers commend highly the Medical Association of Georgia's MCE data system. The development of the MCE system reflects great credit upon the MAG EMCRO Committee and its dedicated efforts to create this data system for medical audit.

Mr. Speaker, your committee recommends approval of Recommendation 1—assumption by MAG of the responsibility for aiding physicians in developing effective medical care evaluation programs; Recommendation 2—endorsement of MCE and its recommendation to medical staffs and hospitals; and Recommendation 3—renaming and continuing the EMCRO committee as the Committee on Medical Care Evaluation Systems.

HOUSE OF DELEGATES ACTION—Adopted Recommendations 1, 2 and 3 of the report of the Committee on EMCRO.

RESOLUTION 9-75
FISCAL AUDIT

W. Daniel Jordan, M.D., Delegate
Medical Association of Atlanta

WHEREAS, the concept of quality audit, being defined as the retrospective evaluation of medical care delivered, has been endorsed and encouraged by the Medical Association of Georgia; and

WHEREAS, the concept of medical necessity, being defined as the decision concerning the need for continuing hospitalization, has been accepted and these decisions rendered by functioning groups within hospital medical staffs; and

WHEREAS, the concept of fiscal audit, being defined as the application of prospectively set criteria of norms and standards of diagnosis, care, and treatment to an individual patient setting for the purposes of determining payment, has been established by third party payors and promulgated under the guise of utilization review; therefore be it

RESOLVED, that the Medical Association of Georgia declares the above defined concept of fiscal audit as being in violation of Section VI of the AMA Code of Ethics,* that it is indeed unethical and unprofessional; and be it further

RESOLVED, that the Medical Association of Georgia refuse to participate in programs involving this concept and that it strongly urges that its component societies and individual members not participate in programs designed for this purpose.

REFERENCE COMMITTEE RECOMMENDATION —Both during the committee hearing and during its executive session, the members of your Reference Committee had considerable difficulty in distinguishing the precise meaning of the term "fiscal audit." Substantial agreement with the apparent intent of this resolution was expressed by your Reference Committee; however, due to the possible misinterpretations which might occur in identifying instances of fiscal audit, your committee feared that adoption of this resolution might result in greater restrictions being placed on medical care delivery.

Mr. Speaker, your Committee recommends that Resolution 9-75 be referred to the Committee on Private Practice for further consideration and clarification.

HOUSE OF DELEGATES ACTION—Approved the report of the Reference Committee referring Resolution 9-75 to the Committee on Private Practice for further consideration and clarification.

PSRO Preamble

Mr. Speaker, my fellow delegates, your Reference Committee considered all the resolutions and reports on PSRO together and makes the recommendations that follow in the hope of expediting the business before us today.

This House has considered the issue of PSRO for the past two years, starting with the Augusta meeting in May of 1973, then the Special Session in Atlanta in December of 1973, the Savannah meeting last year, and again here today. During these two troublesome years for organized medicine, we have been assailed from every side by hostile legislation; we have had to face the unpleasant and discouraging prospect of being divided among ourselves on the question of what action is appropriate on PSRO. There is no doubt that we have been in agreement on the fact that this is a bad law; but, unfortunately, we have been unable to agree on how to react to this destructive legislation and at the same time protect our patients and preserve the private practice of medicine that we hold sacrosanct.

The PSRO Committee in the statement accompanying its Membership Opinion Poll, reflected the conclusions of most of us here today on the PSRO law: "PSRO is destructive legislation. It will increase the cost of medical care. It will decrease the quality of medical care. It will diminish the efficiency of medical care. It will set a precedent for a degree of invasion of the federal government into individuals' private lives hitherto unheard of and unacceptable." The PSRO Committee further concluded that, "it is the law. Repeal at this time seems unlikely. Until and unless organized medicine can get the law changed or repealed (and we must continue our efforts in this direction) there will be a PSRO in Georgia."

In response to the question, "Should MAG (or its subsidiary) apply for designation as agent for implementing and operation of PSRO in Georgia?," 1,777 MAG members responded "yes"; 417 responded "no"; and 160 were "undecided."

The validity of such a plebiscite was questioned by some during the Reference Committee hearings, but your committee feels the poll reflects an authentic expression of the respondents' judgment. It appears unlikely that a significant proportion of members could have misinterpreted the conclusions stated by the committee or the question that was asked. My fellow delegates, 75 per cent of our members responding to the poll have said "yes" to participation in PSRO by the Medical Association of Georgia.

In order to present for the consideration of this House recommendations which we hope will establish a position for MAG that is at once coherent, practical and least divisive, we have considered together all the reports, recommendations and resolutions dealing with PSRO. While some of these thoughtful documents are in general agreement and some are in conflict with the conclusions of your Reference Committee, it was felt that a consolidated expression of position was indicated.

Therefore, we would propose to consider individual recommendations and resolutions first and, finally, to propose a single expression of what we feel should be MAG policy.

RESOLUTION 3-75
PSRO

Bob R. Maughon, M.D., Delegate,
Muscogee County Medical Society

WHEREAS, the Secretary of Health, Education and

* "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

Welfare will establish a Professional Standards Review Organization for the State of Georgia, now therefore be it

RESOLVED, that the Medical Association of Georgia undertake all necessary steps to qualify as the Professional Standards Review Organization for the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends that Resolution 3-75 not be approved.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 3-75.

RESOLUTION 5-75 IMPLEMENTATION OF PSRO IN GEORGIA

John P. Heard, M.D., Delegate, DeKalb County Medical Society

BE IT RESOLVED, that the Medical Association of Georgia not become involved in the implementation of PSRO in Georgia but leave this responsibility to the Federal Government.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends that Resolution 5-75 not be approved.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 5-75.

RESOLUTION 12-75 IMPLEMENTATION OF PSRO BY THE MEDICAL ASSOCIATION OF GEORGIA OR ANY SUBSIDIARY CORPORATION IN THE STATE OF GEORGIA

Bibb County Medical Society

WHEREAS, the recent poll of MAG members concerning implementation contained some unclear wording; and,

WHEREAS, a secret ballot poll of the Bibb County Medical Society taken at the April meeting, at which there was a quorum, the result was 10 to 1 *against* implementation of PSRO by the MAG or any subsidiary organization; and,

WHEREAS, PSRO a law is no less objectionable than PSRO as a concept, in which form it has been twice rejected by the House of Delegates of the MAG,

BE IT THEREFORE RESOLVED, That the MAG or any subsidiary organization not assist in implementing this travesty against our patients and, instead, leave the implementation to the Federal Government and its minions.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends that Resolution 12-75 not be approved.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 12-75.

RESOLUTION 14-75 PSRO

John P. Heard, M.D., Delegate, DeKalb County Medical Society

WHEREAS, there are at least three bills which are being introduced into Congress calling for 19 amendments to the PSRO law and it is expected that the Georgia Congressional Delegation, with possibly one exception, will enthusiastically support these amendments, and

WHEREAS, the official position of the American Medical Association is to exert its leadership by supporting constructive amendments to the PSRO law, and

WHEREAS, it is not likely that the amendments will pass if there is no resistance to the law, such as from those states previously seeking repeal, and

WHEREAS, the PSRO program now faces a severe funding shortage which limits the number of planning contracts to be granted in this fiscal year, and

WHEREAS, the PSRO law states that after January 1, 1976, the Secretary of HEW can appoint an organization without substantial physician representation as a PSRO, therefore be it

RESOLVED, that the Medical Association of Georgia, through its congressional delegation and a resolution to the American Medical Association, seek to extend the deadline for planning contract applications by physician organizations to January 1, 1977, to allow sufficient time for the passage of such amendments, and be it further

RESOLVED, that the Medical Association of Georgia not apply for a PSRO planning grant until meaningful amendments are effected.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends that Resolution 14-75 not be approved.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 14-75.

PRESIDENT-ELECT

David A. Wells, M.D.

The past year has been a very busy and eventful one for the Medical Association of Georgia. I am sure that the coming year will be much the same or maybe more so. I will make no attempt, in this report to list the things that have been done or the things I think will need to be done. I plan to address the House of Delegates briefly during the Annual Session.

I urge each of you to study carefully the reports of the committees of the MAG. These reports show the work that has been done by your colleagues and their recommendations.

I have special interest in the report of the Committee on Organization and Functions since I have chaired this committee for the past two years. The full report is in this handbook. I strongly recommend that the changes proposed be accepted and passed. Our Association must be organized so that it can act and react in a rapid and responsible manner.

The PSRO Committee, at the direction of Council, conducted a poll of the membership to determine the

wishes of the membership concerning the MAG making application as the PSRO for Georgia. A very large majority of the responders indicated that the MAG should make this application, I feel that this is a mandate and I urge you to vote this way.

I wish to commend the excellent staff that we have. They are dedicated to the MAG and to the ideals that the members stand for.

I am looking forward to the coming year with pleasure and concern. Give your Council and officers advice as to what you want them to do. Give them your support when they do their best to carry out your orders and also support them when they must act on their own initiative.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends filing of this report for information and commends our President-Elect for his devotion to the Association.

HOUSE OF DELEGATES ACTION—Accepted the report of the President-Elect, commends him for his devotion to the Association and files the report for information.

COMMITTEE ON PSRO

Charles D. Hollis, M.D.

At the MAG Annual Session in May 1974, the House of Delegates voted to continue efforts of the MAG to effect repeal of PSRO legislation. The decision was made to take no steps toward planning for implementation in Georgia, nor to work for amending the legislation, since it was felt that this would compromise the basic repeal effort.

In June, the AMA House of Delegates voted to support, at least for the time being, efforts at implementation by the profession, but at the same time try to obtain meaningful amendments to make the law more reasonable and workable. There is no information at present to suggest that Congressional support for repeal of PSRO is a realistic possibility.

At the present time 43 states are in the process of planning for their state organizations to assume control of the PSRO mechanism or have actually begun implementation. This represents 105 of the 203 PSRO areas. Seven states (Georgia, Louisiana, Texas, Arizona, Oklahoma, Nebraska, and North Dakota) to this point have taken no specific action and Florida has voted to continue working for repeal and recommended to their county medical societies that they poll their members prior to submitting any contract proposal to HEW for PSRO.

The instructions from the House of Delegates, through adoption of the Reference Committee Report in May 1974, were only for the MAG as an organization to study alternative methods of peer review. In accordance with the direction of the House, an ad hoc committee, chaired by Dr. John McCain of Atlanta, was appointed to study alternative mechanisms and this committee has functioned and will render its report.

The PSRO Study Committee had no charge until January 1975, when the MAG Council directed the PSRO Study Committee to make a survey of the general membership regarding its opinion as to whether or not the MAG should involve itself in PSRO activities. An inactive corporation, the PSROG, was already in existence to assume responsibility for operating a PSRO, should the MAG House of Delegates direct the MAG officers to proceed with implementation.

The survey was organized by the PSRO Committee and brief questionnaires with a cover letter explaining the purpose of the survey was mailed to the membership in February. The results of the survey are listed below.

The Council felt that on such a sensitive issue as PSRO that an expression from the full membership would be desirable before taking final action. The House of Delegates is not bound by this survey, but simply will have the benefit of the results of it in making its decision at the Annual Session in April 1975.

The issue still remains as to whether the profession generally feels that the best interests of the physicians and the public will be served by operating the PSRO review procedures through committees of practicing physicians or whether such potentially undesirable and unworkable activities should be left for the HEW to organize and to operate. This decision will have to be made by January 1, 1976, since by law, HEW at that time will have to designate its PSRO agents in each area. HEW is required to offer this opportunity first to the representative practicing physicians in the area, but upon their refusal, to any other group of physicians who apply and express willingness to perform the review activities. Eligible groups would include Blue Cross-Blue Shield organizations, State Health Department, or any other group of physicians incorporated for this specific purpose.

HEW directed that hospitals which accept Medicare-Medicaid patients should institute concurrent review by February 1, 1975. Most hospitals in the state are attempting to perform this function at present.

The MAG, through its Foundation staff, has established the CHEC review mechanism which would meet the criteria of the PSRO for concurrent and retrospective review. There is in operation at present a pilot CHEC program in four hospitals in Georgia (DeKalb County; Tift County; Phoebe Putney Hospital in Albany; and Palmyra Park Hospital in Albany), and preliminary reports are that this experiment is working well and is receiving favorable comments from both hospital administrators and medical staffs. If MAG should decide to operate a PSRO in Georgia, through its subsidiary corporation, the PSROG, the CHEC review mechanism is well established and will be available for use.

The PSRO Committee has met only once and at its meeting made no effort to poll the membership of the committee as to their individual opinions about how the MAG House of Delegates should vote on the PSRO issue. It seemed that since an all membership survey was being performed, that it would be more appropriate simply to publish the results of the survey. Therefore, PSRO Committee is making no specific recommendation to the House of Delegates as to its decision on implementation of PSRO for Georgia.

PSRO Poll by County, as of 4/9/75

	Yes	*No*	*Und.*
	Yes	*No*	*Und.*
Altamaha	1	0	0
Baldwin	20	6	2
Barrow	1	4	0

Bartow	3	0	0
Ben Hill-Irwin	2	1	0
Bibb	66	44	14
Blue Ridge	2	1	0
Ogeechee River	8	2	0
Burke	3	0	1
Car.-Doug.-Har.	20	2	2
Ga. Med. Soc.	103	13	7
Elbert	2	1	1
Chattahoochee	8	0	1
Cherokee-Pickens	12	0	0
Crawford W. Long	37	13	5
Clayton-Fayette	15	5	0
Cobb	96	14	10
Coffee	4	1	0
Colquitt	9	2	0
Coweta	10	2	0
Decatur-Seminole	5	1	1
DeKalb	102	52	12
Dougherty	40	4	5
Camden-Charlton	2	1	0
Emanuel	2	0	0
Flint	7	2	2
Floyd-Polk-Chat.	35	20	5
Franklin-Hart	5	0	0
Med. Assn.-Atl.	570	97	36
Glynn	28	10	2
Gordon	5	2	0
Habersham	4	3	1
Hall	38	5	1
Peach Belt	15	4	1
Jackson-Banks	2	1	0
Jefferson	2	0	0
Laurens	16	3	1
McDuffie	6	0	1
Meriw.-Harris	4	2	1
Mitchell	1	1	0
Muscogee	87	9	5
Newton-Rockdale	5	1	0
Oconee Valley	4	2	1
Ocmulgee	4	1	0
Rand.-Stew.-Ter.	5	0	1
Richmond	110	38	23
Screven	3	2	0
South Georgia	33	4	2
S.E. Georgia	4	1	1
S.W. Georgia	3	0	0
Spalding	21	5	2
Stephens-Rabun	16	0	0
Sumter	10	2	0
Telfair	1	0	0
Thomas Area	25	3	3
Tift	7	4	0
Troup	22	2	3
Upson	7	2	0
Wakr.-Cat.-Dade	15	5	1
Walton	4	0	0
Ware	15	5	2
Washington	3	0	0
Wayne	3	2	0
Whitfield-Murray	32	4	0
Wilkes	3	0	0
Worth	1	1	1
No Co. Indicated	23	5	3

Total PSRO Poll for Georgia

Yes	*No*	*Und.*
1,777	417	160

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends filing of this report for information and commends the excellent work of the PSRO committee members over these past two years.

HOUSE OF DELEGATES ACTION—Accepted the report of the Committee on PSRO, commended the members of the committee for their work, and filed the report for information.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON PSRO

John P. Heard, M.D., Vice Chairman

CHRONOLOGY OF THE PAST YEAR

Since the last MAG Annual Session in 1974, there have been changes in the status of the PSRO legislation, but regretfully, your PSRO Committee did not meet again until January 29, 1975, over eight months after the Annual Session. By far the most significant change was the acceptance of PSRO legislation by the AMA House of Delegates. This was followed immediately by a grant of almost a million dollars so that AMA could work with PSRO. Many states and local organizations have followed the AMA and have received large grants to plan and to implement PSRO.

These actions were based on the assumption that doctors could implement the law better than HEW and, with certain amendments, the law would be more palatable. First, we believe this to be a false assumption, as all authority over PSRO rests with HEW, and only those actions approved by the Secretary of HEW can be carried out. Second, to this date, 10 months after AMA capitulated, there is no evidence that any amendment will be accepted. In fact, numerous congressional leaders flatly state that the law will not be altered, and *as long as doctors succumb, they do not have to alter their stand.*

Several states have resisted these lucrative grants and have taken no action to work with PSRO, and one state, Florida, has voted to leave it alone and let HEW implement it. The Florida Medical Association has also recommended that none of their component societies should participate in PSRO.

Although the deadline may have to be extended due to lack of funds, effective January 1, 1976 the HEW Secretary may designate someone other than a physician organization as the PSRO in Georgia. Therefore, the House of Delegates must again take a firm stand on this critical issue.

The Executive Committee has voted to recommend to Council that MAG become active in PSRO through PSROG, a wholly owned corporation of MAG which was chartered for this purpose by the Executive Committee in 1973.

The Council was asked to endorse the Executive Committee's recommendation, but Council voted to take no stand. Instead, it authorized an all member mailing to seek the views of the membership on this critical issue. These results are available and though the mailing was prepared by this committee, there is a tre-

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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with moniial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
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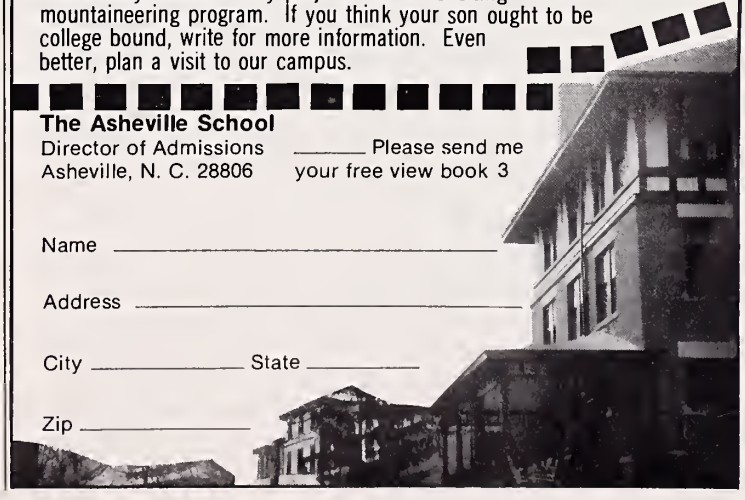
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DeKalb County Delegate John P. Heard addresses the House with a proposed compromise to satisfy differing opinions on the issue of Professional Standards Review Organizations.

mendous confusion concerning this poll. Several resolutions have been submitted which bear out the fact that there is much question concerning the validity of the results.

SUMMARY OF ACTION AT THE 1974 ANNUAL SESSION

At the 1974 Annual Session much time and effort went into the decisions reached by the House of Delegates and it is well that we review these. The following is a detailed summary of the opinions of the Reference Committee which were approved by the House of Delegates, much of which is quoted to avoid misunderstanding:

"It has been pointed out and is recognized by the Committee that the primary underlying evils in the extant PSRO legislation reside in the substructure of the Social Security Act itself, governing Medicare and Medicaid, and it is understood that the PSRO concept in part represents an outgrowth of efforts to institute physician review rather than lay review of medical practice. It is also recognized that dissolution of the PSRO concept would still leave unmodified the authority of the Department of HEW to regulate much of medical practice. It is further perceived by the Committee that the concept of peer review is eminently to be desired over review and regulation by unprofessional administrative and hence, inadequately trained personnel.

"Nonetheless, the Committee views existing PSRO legislation as providing onerous roadblocks to the effective prosecution of quality medical care, holding no hope of reducing medical costs but rather escalating them; as constituting a substantive threat to the medical welfare of the consumer, the patient; and, most of all, as offering insuperable interference with the concept that the delicate process of physician decision making, difficult as it often is, should go forward unimpeded by arbitrary legislative and fiscal considerations imposed from without.

"This position has already been endorsed and impressively activated by the MAG and great progress has been made.

"It is, therefore, the unanimous opinion of Reference Committee C that all efforts should be directed toward unqualified repeal of PSRO. No present efforts should be expended in the lesser task of seeking amendment.

"Efforts to obtain planning contracts while seeking repeal are viewed as inconsistent, diversionary, and unworthy of a group with such solidarity of purpose.

"In order to be certain that our intentions in opposing and seeking the repeal of the PSRO Law are understood by Congress and by our patients, your Reference Committee believes that certain issues should be clarified. *In seeking repeal of the PSRO legislation, the MAG membership does not seek to shirk its responsibility for accountability for federal funds spent in the Medicaid and Medicare programs. We firmly believe that a better mechanism for providing accountability can be developed and that the physicians themselves should be the ones to develop it. The concept of peer review was developed by physicians, not by HEW, and there should be continued exploration of various methods of peer review.*

"In vigorously working for repeal of the PSRO law, we do not deny the need for quality of care assessment. Indeed, we reaffirm our commitments to quality of care assessment and re-emphasize the importance of performing utilization review at the local level and we concur with the necessity for assessment of appropriateness of care provided to patients, as performed by the local hospital medical staff and/or local medical society. Further, we rededicate ourselves to the concept of quality of care by reaffirming our commitment to continuing medical education."

A year ago the Reference Committee made the following recommendations concerning PSRO which were approved by the House of Delegates, and we regret that these ideas have not been pursued to the fullest:

1. "Continue to vigorously work for repeal of PSRO."
2. ". . . withdraw the application to HEW for a planning contract"
3. "Communicate the above decisions to the AMA House of Delegates the various state medical associations and our congressional representatives making the *issue clear* as to MAG's position on PSRO."
4. "Instruct our AMA delegation to
   a. Maintain a clear, unencumbered position for repeal of PSRO.
   b. Prepare and introduce appropriate resolutions at the AMA to establish a concise, stable position for repeal of PSRO and to cease and desist from further efforts to implement or amend what has been generally accepted as a bad law."
5. "Continue to explore the methods of true peer review"
6. ". . . recommend that MAG formally declare its belief that some system of cost underwriting protection should be devised for those Americans

confronted with" a catastrophic illness or accident.

Your PSRO Committee feels that these recommendations were carried out to a varying degree, with little effort being applied to the task of unifying those state associations working for repeal into an effective force by advertising our success prior to AMA Annual Convention in June 1974. This was our greatest failure because we had developed a repeal effort that attracted national prominence and we were expected to provide guidance and direction within the repeal movement. Regretfully, a unique position of national leadership for MAG was lost.

Further, Resolution 74-9 by the Bibb County Delegation, which beautifully states our ethical position, was approved with commendation, and is quoted in full:

"THEREFORE, BE IT RESOLVED, that since PSRO is designed to decrease hospital cost for Medicare and Medicaid patients by limiting hospital care, but DOES NOT control the rising hospital costs due to the effect of changing minimum wages, and,

DOES NOT control inflation's influence on rising hospital costs, and,

DOES NOT limit the rising number of beneficiaries of Medicare and Medicaid coverage, and,

DOES NOT regulate the additional procedures and treatments that these programs are assigned by the Government which result in higher costs, and

DOES NOT curtail the expansion of these programs into physio-therapy and chiropractic, and,

DOES NOT induce incentives to the patients to limit excessive demands for medical care under these programs, and

Thus, we hereby conclude that PSRO is inappropriately oriented in its effort to effect the rising costs of government medical expenditures for Medicare and Medicaid.

But, more importantly, since we basically agree that it is wrong to impose a program on patients and physicians which makes it difficult to admit and care for hospital patients and jeopardizes the confidentiality and intent of the doctor-patient relationship, and

Since involvement in such a program is thus directly contrary to the Code of Medical Ethics of the American Medical Association and the Medical Association of Georgia, *we hereby state that we will in no way involve ourselves in the organizing of a Georgia Professional Standards Review Organization.*"

RECOMMENDATIONS FOR 1975 ANNUAL SESSIONS

At the present time, we do not feel we can repeal this piece of bad legislation, though this can change in the future. Indeed, since it has been accepted by AMA, we have lost a great deal of leverage, but the AMA is finding it most difficult to amend this law. No one in Congress seems to be listening to them, and this will surely be debated again at the AMA Convention in June 1975. With other equally objectionable portions of PL 92-603 being forced on us at this time. AMA has become sufficiently aroused to file suit to stop them. Ironically, these have most of the same unacceptable characteristics of the PSRO legislation.

Although this ill conceived and unworkable law has been embraced by the AMA and others, nothing has changed to make it more acceptable to your committee.

Therefore, the undersigned members of your PSRO Committee make the following recommendations to the House of Delegates of the 1975 Annual Session:

1. Do not attempt to implement PSRO in Georgia as the law as written is still totally unworkable and doomed to failure.

2. We should urge all component societies of MAG not to participate in the formation of a PSRO, as long as the law remains as written.

3. We should again make a serious attempt to inform the public of the various detrimental laws that have been passed to ration medical care under the guise of cost containment and peer review, when we know better than anyone that it will increase cost and reduce quality; it will make it more difficult and costly for the patient to obtain quality medical care, and allow nonprofessional bureaucrats to intercede in the physicians' judgments regarding patient care.

4. We should make our intentions known to the AMA House of Delegates at the Annual Convention in June 1975, through our delegation, and should enter a resolution asking the AMA to launch a similar public campaign, financed by a special assessment if necessary.

5. We should notify other State Medical Associations of our action.

6. We should urge all MAG members to continue to participate in true peer review in order that we may continue to improve the already high quality of health care rendered in our state.

CONCLUSIONS

We feel that to reverse our stand from last year, so eloquently expressed after intense and thoughtful study, is inconceivable. Capitulation to bureaucratic pressure will demonstrate that the high ethical standards we so proudly claimed last year are no longer meaningful. The odds are against us, but to acquiesce now will mean we no longer have the will to carry on even though we are sure we are in the right.

Consider the words of Sir Winston Churchill:

> "Still, if you will not fight for the right when you can easily win without bloodshed; if you will not fight when your victory will be sure and not too costly; you may come to the moment when you will have to fight with all odds against you and only a precarious chance of survival. There may even be a worse case. You may have to fight when there is no hope of victory, because it is better to perish than to live as slaves."

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends that all of the recommendations be not approved and that the report be filed for information.

HOUSE OF DELEGATES ACTION—Disapproved the recommendations of the supplemental report of the Committee on PSRO and filed the report for information.

BIBB COUNTY MEDICAL SOCIETY COUNCILOR

Milton I. Johnson, Jr., M.D.

(For full text of Bibb County Medical Society Councilor's report, see reports referred to Reference Committee A.)

RECOMMENDATIONS

1. It is recommended that, when the question comes before the House of Delegates, they continue their strong opposition to participating in the implementation of the so-called PSRO Law. The immediate and ultimate detrimental effects of this law are too well known to merit further detailed discussion. Let the federal government set up their little machine and when it fails, let's not be the goat. Let's refuse to have the Medical Association of Georgia apply for any funds or any designation as a PSRO.

2. Concurrent Hospital Review, Federal Register Vol. 39, No. 231, 11-29-74. Since we have not been able to get any further help from the American Medical Association to fight this unwarranted fiat, it is recommended that the Medical Association of Georgia notify the Secretary of HEW as to our opposition to this regulation. It is further recommended that our legal counsel investigate the feasibility of filing a lawsuit to have this regulation declared illegal. We should also investigate the feasibility of pooling our resources with those of other states and filing a joint suit in this matter.

4. Amendments to PSRO. We have commitments from many members of our congressional delegation who have introduced bills to repeal PSRO, but we do not know the status of these bills. The most that we have been able to get out of Senator Talmadge is that he feels that some amendment to this odious law is indicated. It is recommended that we pursue this vigorously and exert pressure to see that amendments are introduced. This approach is not necessarily a schizophrenic attitude on our part because it is an accepted tactic in war to frontally assault your enemy while at the same time one seeks to destroy him from within.

REFERENCE COMMITTEE RECOMMENDATION—Mr. Speaker, your Reference Committee recommends that Recommendations 1, 2 and 4 of this report be not approved.

HOUSE OF DELEGATES ACTION—Disapproved Recommendations 1, 2 and 4 of the report of the Bibb County Medical Society Councilor.

Consolidated PSRO Position

While your Reference Committee continues to feel that repeal of the PSRO provisions would be most desirable, the stark realities of the legislative scene indicate by now that this is a hopeless wish. Rather, Mr. Speaker, your Reference Committee recommends adoption of the following position:

Every effort should be made by the Medical Association of Georgia in cooperation with the American Medical Association to seek amendments to the PSRO law to remove its most onerous provisions. This campaign should be directed by Council itself or through an appropriate committee.

Mr. Speaker, it is clear that the PSRO law, though impractical, deleterious, and uneconomical, will, indeed, become operational in Georgia and become operational in essentially its present form. In view of this inevitable fact, it becomes the responsibility of Georgia's physicians to do their utmost to dampen the impact of these unwanted governmental pressures upon their patients. It is the opinion of your Reference Committee that this can best be done by directing as much as possible the administrative machinery ourselves, rather than allow the appointment of an unqualified, probably non-professional group. Furthermore, the membership has expressed its recognition of these facts through its unequivocal response to the poll.

Consideration was given to the possibility of delaying final decisions on application for a planning grant until later in the year, at which time a special meeting of the House of Delegates could be called. As a matter of fact, your committee deliberated at some length over this question, and final opinion was divided. However, it was the opinion of a majority of the committee that little is likely to be accomplished in this interval; that the members of MAG have been suspended on tenterhooks long enough on this issue; and, that the responsibility for this decision should be shouldered here and now by this Reference Committee and this convened House.

Therefore, Mr. Speaker, Reference Committee B *recommends that MAG, through its subsidiary, PSROG, should apply now to the Department of Health, Education & Welfare for a planning contract to develop a PSRO for Georgia.*

HOUSE OF DELEGATES ACTION—Delegate John P. Heard, Decatur, moved to amend the recommendation of the Reference Committee by deleting the word "now" and inserting in lieu thereof the words "15 days prior to the deadline for physicians to receive priority consideration" so that the amended recommendation would read:

"That MAG through its subsidiary, PSROG, should apply 15 days prior to the deadline for physicians to receive priority consideration to the Department of Health, Education and Welfare for a planning contract to develop the PSRO for Georgia."

The substitute recommendation of the Reference Committee was then adopted as amended by the House.

Chairman Waters expressed his appreciation to the members on the Reference Committee for their time and effort and for the assistance provided to the committee by the officers and others. He then moved that the report be adopted as a whole as amended. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE C

Joseph P. Bailey, M.D., Chairman

Chairman Bailey reported to the House of Delegates that the reports and resolutions referred to Reference Committee had been considered by the committee which met at 1:30 p.m. in the Fulton Room, Fairmont Colony Square Hotel, Atlanta, Georgia, on April 18, 1975. Members of the com-



Reference Committee C

mittee present included: Joseph P. Bailey, M.D., Augusta, Chairman; Robert E. Jennings, M.D., Arlington, Vice Chairman; Daniel B. Stephens, M.D., Marietta; James R. Meacham, M. D., Summerville; Joseph L. Girardeau, M.D., Atlanta.

GEORGIA MEDICAL SOCIETY COUNCILOR

L. Richard Lanier, Jr., M.D.

The Georgia Medical Society has noticed in our area a chronic shortage of skilled nurses, and this must be common throughout the state.

In Savannah there has been an attempt to overcome this shortage by importing nurses from other countries, particularly the Philippines. This would seem to be the same one-shot solution that foreign medical graduates have played in medical practice, but extended to nursing.

Traditionally, we in medicine have been rather divorced from the policies and plans of nursing as a profession except as it was immediately concerned in our own hospitals.

Since the nursing training programs have been moved out of the hospitals and into the Board of Regent's colleges, with the development of a two year associate degree nursing program, we feel that these programs have not lived up to the expectations, either in the numbers or the proficiency of the graduated nurses. The hospitals have to bear the brunt of the training of clinical skills to these nurses; those skills that have in the past been developed in a three or four year nursing program.

There is an apparent increased tendency to the development of further two year nursing programs wherever there is a junior college. We would question whether this is wise: in as much as many of these areas do not have adequately trained personnel to provide the teaching or the facilities for the clinical training. It would appear that money spent for this would be better spent increasing the enrollment at the largest centers and extending their clinical training. We believe that MAG should take appropriate actions to investigate the importance of the shortage of nurses throughout the state and to determine the number of graduates from the various levels and types of nursing schools, their clinical usefulness and appropriateness of their training. It would also be appropriate that we attempt to encourage the development of plans and programs to attract the nurse who is not utilizing her clinical skills, into appropriate areas of nursing.

We should have liaison with the State Board of Nursing Examiners and the Board of Regents concerning this problem and see in what method the MAG can be of help improving the situation. Included in this suggestion would be that the three year program be resumed. These graduates would thus receive an increase in clinical training, making it possible to utilize them in the hospital situation, without in effect, giving these associate degree graduates a year of paid internship.

The cost and responsibility of training student nurses should be borne by the Board of Regents rather than by the individual hospital.

RECOMMENDATIONS

1. That the MAG through appropriate means, become more involved in the planning and the direction taken by nurses training programs, and in particular, that we attempt to develop a more active role in recommending the clinical skills and experiences that these nurses are receiving.

This would entail considerable active liaison with both the Board of Regents, the Nursing Board of Examiners and the State Nursing Associations.

2. That MAG have an active roll in the development and continued supervision of all paramedical programs developing or anticipated in the schools under the Board of Regents, and in other institutions where we are requested to do so.

FIRST DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Georgia Medical Society				
J. Robert Logan				
Savannah	219	200	209	193

REFERENCE COMMITTEE RECOMMENDATION —Recommendation 1 calls for the Medical Association of Georgia to become more involved in the planning and direction of nurse training programs administered by the State Board of Regents.

Mr. Speaker, your Reference Committee is in agreement and therefore recommends the approval of Recommendation 1.

Recommendation 2 calls for the Medical Association of Georgia to take an active role in the development and continued supervision of all paramedical training programs under the Board of Regents and other institutions.

Your Reference Committee feels that this recommendation is not based on sufficient information.

Furthermore, it observes that a suitable mechanism for studying problems relating to the training

of paramedical personnel already exists within the structure of the MAG, specifically with the Committees on Physician's Assistants and Allied Health.

Mr. Speaker, your Reference Committee recommends that Recommendation 2 be not approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Georgia Medical Society Councilor.

COMMITTEE ON ANNUAL SESSION

LaMar S. McGinnis, M.D.

Business Session

In May 1974 the first two day business meeting of the Association was held in Savannah. The 1973 House of Delegates had approved the division of the Annual Session into a business and scientific meeting each year.

During this business session the House of Delegates met twice, there was a memorial service and an awards ceremony held, an election and installation of officers, and a reception for the President. As there was general approval of this format for the business session, it will be repeated in April 1975.

RECOMMENDATION

1. That the Association's Annual Session continue with this spring meeting to transact the business of the Association.

Scientific Session

The 1975 Scientific Session, meeting separately from the Annual Business Session for the first time, will be held on November 21-22 in Atlanta. Under the old arrangement of holding the Annual Business and Scientific meetings concomitantly, there was an undesirable competition between business and science for attending physicians' time. Consequently, the 1973 House of Delegates elected to divide the Business and the Scientific portions of the Annual Session and to hold the Scientific meeting in the fall. There was no Scientific Session in 1974 because the planners did not feel that they had ample enough opportunity to plan for the kind of quality program they desired.

The format of the 1975 Scientific Session will be as follows: An opening luncheon with guest speaker for all attending physicians and their wives, followed by two half-days of programs planned and sponsored by those state medical specialty societies who choose to participate. MAG will provide speakers' funds for each of these programs. There will also be an educational program for attending physicians' wives in such areas as the arts and humanities. A registration fee for the Scientific Session will cover the cost of the luncheon and a cocktail party. The annual MAGNET Conference will be held in the same hotel immediately after the Scientific Session.

MAG's role in the Scientific Session will be primarily one of support and coordination of continuing education programs for physicians and their wives.

RECOMMENDATIONS

1. That the Medical Association of Georgia give its wholehearted approval and adequate financial support to the 1975 Scientific Session.

2. That the continuance of an annual fall Scientific Session be based upon an evaluation of the success of the 1975 meeting.

REFERENCE COMMITTEE RECOMMENDATION —Recommendation 1 of the section on Business Session expresses the wishes of the Committee to continue the spring meeting in order to transact the business of the Association.

Mr. Speaker, your Reference Committee recommends that this recommendation be approved.

Recommendations 1 and 2 under the section on Scientific Session call for the Medical Association of Georgia to give wholehearted and adequate financial support to the 1975 Scientific Session. Furthermore, they advise that the continuance of the Scientific Session be based upon an evaluation of the success of the 1975 meeting.

Mr. Speaker, your Reference Committee recommends approval of Recommendations 1 and 2 under the Section on Scientific Session.

HOUSE OF DELEGATES ACTION—Adopted the recommendations of the Committee on Annual Session.

COMMITTEE ON EDUCATION

Nicholas E. Davies, M.D.

This Committee, with 51 members, is the largest in the MAG. It is divided into four subcommittees: Continuing Medical Education, Nursing (Joint Practice), Medical Schools, and Public Education.

The Education Committee has remained well within its budgetary limits this year, spending less than half of its authorized budget of $2,400. This budget, with additional funds received from the Regional Medical Program, is far below that of Education Committees in neighboring states.

The following are the accomplishments of the Committee and subcommittees:

1. **Stephen Daniel, Ph.D.,** was hired as MAG's new Assistant Executive Director—Education on October 1, 1974. His salary is funded jointly by the MAG and the RMP. Dr. Daniel will work primarily with Continuing Medical Education and the Annual Scientific Session.

2. **Accreditation** of educational programs by the Continuing Medical Education Subcommittee has been actively pursued. Thus far seven organizations have been surveyed and accredited and 13 others have requested applications for accreditation. The surveys have been conducted by 19 physicians who have donated approximately 180 hours for this work.

3. **Hospital Education Programs.** The MAG assisted the Georgia Heart Association in producing a cardiology lecture at Tift General Hospital. This is the first of many programs that the MAG will help to produce in community hospitals in conjunction with the continuing education programs of our medical schools, medical specialty societies, and voluntary health organizations.

4. **The Public Education Subcommittee** has been formed as a result of the 1974 meeting of the Medical Schools Subcommittee, in which it was pointed out that there was no one in Georgia who assumed responsibility for disseminating factual health information to the public. It seemed reasonable that physicians, as

leaders in the health community, should assume at least part of this responsibility.

5. **A Task Force to Study Relicensure** met informally in November 1974, and the question of relicensure was then presented to the entire Education Committee. The majority on this Committee felt that the MAG should not require CME for membership at this time nor should it recommend mandatory CME to the State Board of Medical Examiners as a requirement for relicensure. The reasons given for this were:

a. we should not require a specific number of CME hours in accredited programs until the state has a sufficient number of accredited programs for its physicians to attend;

b. some physicians felt that requiring CME was not the answer to the problem of accountability and that a better way might be found to do this, perhaps through the use of practice audit. The Education Committee will review the relicensure situation annually.

6. **The Physicians' Recognition Award of the American Medical Association** is being promoted by the Education Committee. Taking into account its shortcomings, the award appears to be the best method available to providing incentive to and measuring of a physician's efforts toward continuing his education.

7. **Two Manpower Studies** are underway in Georgia, one as a direct result of the Medical Schools Subcommittee meeting in 1974, the other an indirect result of this meeting. We hope that information will be forthcoming regarding the distribution of physicians in the state so that better planning can be done to help communities secure physicians.

8. There is an excellent relationship between our **medical schools and the Medical Association of Georgia,** with the outlook of increased cooperation as the Continuing Medical Education programs go forward during the remainder of this decade and into the 1980's. The medical schools are well represented on the Education Committee and help considerably in its planning. We believe that this will eventually strengthen not only the Education Committee but the entire Association.

9. The Education Committee endorsed the **proposal of the Georgia Council for Family Practice Education** for direct legislative funding to promote increased training of family physicians in community hospitals about the state. Hospitals with such programs are located in Macon, Columbus, Rome, Augusta, and Fort Gordon.

FUTURE PLANS

The Education Committee will concentrate its efforts on two broad fields: 1) The continuing education of physicians in Georgia, whether or not they are members of the MAG; and 2) the education of the public regarding health matters.

The Continuing Medical Education Subcommittee is working under the following general assumptions:

A. Practicing physicians usually learn best from their own patients.

B. Education should be a day-to-day process, not a monthly or yearly affair.

C. Education of practicing physicians should be conducted in community hospitals on a continuing basis.

D. The MAG cannot afford to educate all physicians in the state; indeed, it cannot afford to educate its own members adequately.

E. The community hospitals where most Georgia physicians practice appear to be the best places to concentrate educational efforts.

Working under these assumptions, the CME Subcommittee has the following general objectives:

A. Encourage *as strongly as possible* each community hospital to institute an educational program for physicians or upgrade its present program.

B. In every way possible, assist community hospitals in developing educational programs.

C. Identify physicians throughout the state who are interested in Continuing Medical Education and help them with their own educational efforts.

D. Sponsor programs for hospital medical educators, herein defined as any person concerned with medical education programs in hospitals, from full-time salaried directors of medical education to voluntary local medical doctors who want to keep up with what is going on.

E. Show hospitals how to do medical audits for educational purposes, and help develop educational programs utilizing the resources of medical schools, voluntary health agencies, and the suppliers of audiovisual materials.

The Public Education Subcommittee has not had the opportunity to set its objectives as clearly as has the CME subcommittee. The task of public education is almost overwhelming in its complexity. It begins at home with mothers medicating their infants and extends into schools with classes in "hygiene," physiology, biology, sex education and the advanced sciences. It involves all the media, which are now a vast wasteland of half-truths and misinformation. Tangible results will be hard to identify.

Goals of the Public Education Subcommittee for the coming year may include:

1. Evaluation of health education in state school systems, especially on the primary and secondary levels.

2. Joining with voluntary health agencies in specific media campaigns: e.g., smoking, alcoholism, venereal disease.

3. Promoting health education courses in teachers' colleges, i.e., teaching the teachers what to teach.

4. Close liaison with the Public Health Committee and others concerned with education of the public regarding health matters.

RECOMMENDATIONS

The Education Committee recommends that the Medical Association of Georgia continue its emphasis on education for physicians and the general public by:

1. Becoming more active in community hospital education programs for both physicians and the general public, by upgrading existing programs, and by promoting new programs.

2. Encouraging more community hospitals and other organizations to apply for accreditation of their programs by the MAG and the AMA.

3. Continuing to promote the Physicians' Recognition Award of the AMA, which is now required for membership by 12 state medical societies in the United States.

4. Promoting medical audit in community hospitals as a method to determine educational needs and to plan educational programs.

5. Encouraging and assisting the state medical schools in continuing to improve their Continuing Education programs and to promote actively these programs in community hospitals.

6. Encouraging all the voluntary health agencies to develop educational programs for physicians that can be presented in community hospitals.

7. Continuing to follow the progress of relicensure legislation within the various states.

8. Beginning to promote public education in health matters in close liaison with other MAG committees.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee considered in detail this very comprehensive report of the Committee on Education which outlines the Committee's accomplishments over the past year and lists a number of goals for the future. In line with its activities and planning, the Committee makes eight specific recommendations under the general recommendation that the Medical Association of Georgia continues its emphasis on education for physicians and the general public. Your Committee considered the eight specific recommendations individually.

Recommendation 4 describes medical audit in community hospitals as a method of determining educational needs. Your Reference Committee wishes to point out that approval of medical audit does not imply approval of PSRO or other government programs.

Mr. Speaker, your Reference Committee agrees wholeheartedly with all of the specific recommendations and therefore recommends that the House of Delegates approve all of the recommendations of the Committee on Education.

In the context of public education, your Reference Committee further recommends that the Education Committee of the Medical Association of Georgia develop a mechanism for reviewing submitted public health education programs in order to determine their validity.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Education.

COMMITTEE ON MATERNAL AND INFANT WELFARE

Luella Klein, M.D.

During 1974 the Committee on Maternal and Infant Welfare met several times to review maternal deaths and to discuss legislation and health care in the field of maternal and infant care.

LIVE BIRTHS AND BIRTH RATE

There were 85,285 live births in 1973. The birth rate decreased to 17.8 (18.5 in 1972), due to a decrease in both the white and black live-birth rates. (Preliminary data indicates that there was a decrease of total live births in 1974.)

Hospital deliveries reached a high of 98.4 per cent in 1973 compared to 98.1 per cent in 1972.

MIDWIFE DELIVERIES

There were 763 live births at home attended by lay midwives in 1973. There were 995 deliveries in hospitals by Certified Nurse Midwives.

NEONATAL AND INFANT DEATHS

	Total	Rate	Black	Rate	White	Rate
Infant Deaths (Under 1 year)						
1973	1,634	19.2	765	26.1	869	15.5
1972	1,733	19.8	827	27.6	906	15.8
Neonatal Deaths						
1973	1,097	12.9	461	15.7	636	11.4
1972	1,193	13.7	503	16.8	690	12.0

The number of fetal deaths is not presently available with accuracy, so fetal and perinatal death rates are not included.

BIRTHS TO UNWED MOTHERS

There were 11,529 live births to unwed mothers (13.5% of total live births) a decrease of 164 over the previous year. However, the rate rose from 133.8 to 135.2 between 1972 and 1973. Live births to white unwed mothers (2,038) increased by 62 and live births to unwed nonwhite mothers (9,491) decreased 226 from the previous year.

ADOLESCENT PREGNANCIES

Live births to adolescents have increased to 26.3 per cent of total live births. Of live births to unwed mothers, 56.2 per cent were to adolescents. During 1973 one out of every seven infants live-born to an unwed adolescent was premature by weight at birth, compared to one out of nine in 1972. There were 730 live births to girls under 15, 9,598 to girls 15-17, and 12,054 to girls 18 and 19.

LIVE BIRTHS BY AGE, PARITY AND EDUCATIONAL ATTAINMENT OF MOTHER

During 1973 the median age of white mothers was 24½ years and the median age at time of birth of the first liveborn infant to white mothers was 22¼ years. Among nonwhite mothers the median age was 23 years and at the time of the first birth 19½ years. Twenty-six per cent of the white live births were in the third or greater order while 36 per cent of the nonwhite were third or greater order.

This year for the first time we have been able to look at the educational level of attainment of the mother at the time of birth of this infant (93.4 per cent of live birth certificates reported educational level of achievement of mother). Sixty per cent of all mothers had completed the 12th grade or more (white 65 per cent and nonwhite 49 per cent). If mothers under 20 years of age are eliminated, 66 per cent of the mothers had completed high school educational level (white 69 per cent and nonwhite 59.5 per cent).

MATERNAL MORTALITIES

There were 18 maternal deaths in Georgia in 1972 out of a total of 85,285 live births. The death rate of 2.1 per 10,000 live births represented a decrease from the 2.7 rate of 1972. Thirteen deaths occurred to nonwhite and five to white women. The greatest cause of death was given as embolism (3). Hemorrhage was the cause of five deaths, ectopic pregnancy (2), ruptured uterus (2) and abruptio (1). Three deaths were attrib-

uted to toxemia of pregnancy. Two deaths were attributed to infection, criminal abortion (1) and postpartum sepsis following caesarian section for arrested labor (1). One death was caused by cardiac arrest during postpartum tubal ligation.

PREMATURE BIRTHS

In 1973 there were 7,496 premature live births for a rate of 87.9 per 1,000 live births (decreased from 88.4 in 1972). The rate of prematurity at birth is almost twice as frequent in the nonwhite as in the white race. The age of the mother significantly affects the rate of "low birthweight" live births.

RATE OF LIVE BIRTHS LESS THAN 2,500 GRAMS PER 1,000 LIVE BIRTHS

	W	N-W
Total	66.9	128.5
Less than 18 years of age	91.8	157.6
18-19 years of age	77.2	136.1
20 years and over	62.5	117.6

ABORTIONS

In calendar year 1973 there were 12,301 legal abortions reported to the Department of Human Resources. This is a ratio of 114 abortions per 1,000 live births. There was one maternal death caused by sepsis following criminal abortion.

The ratio of abortions to white live births was 145 and for nonwhite 141 per 1,000 live births. By age groupings the ratio was 336 for women less than 15 years of age; 180 for women 15-19; 117 for those 20-34; 230 for those 35-39, and 246 for women 40 and over.

By estimated duration of pregnancy 88.5 per cent of legal abortions were under 13 weeks, 11 per cent 13-20 weeks and 0.5 per cent greater than 20 weeks. Approximately 75 per cent of the patients were reported as unmarried at the time of the abortion, and 56 per cent were reported to have no living children.

PUBLIC HEALTH MATERNAL HEALTH SERVICES

During FY 1974, 15,669 women received prenatal care through medical and nursing clinic services in local public health departments; 12,095 were new admissions and 3,574 were carried over from the previous year. By gestational duration at time of admission, 30.3 per cent were admitted under 16 weeks, and an additional 47.3 per cent were admitted between 16 and 27 weeks.

During FY 74 a new program—maternity care for the medically indigent was inaugurated. This program (MAT-PAK) provided limited payment to physicians and hospitals for delivery of medically indigent women. Approximately 2,800 women were served by this program. The program is currently undergoing revision to provide services to selected high risk patients in order to reduce maternal and neonatal morbidity and mortality.

FAMILY PLANNING

As of June 30, 1974, there were 84,250 women actively participating in the Department of Human Resources' statewide Family Planning Program (1973—73,000). During fiscal year (1974) there was an unduplicated total of 102,358 patients, served through 154,243 visits. Family Planning services were provided to approximately 12,000 additional women through Medicaid. By age grouping, 26.5 per cent of the active patients were under 20 years of age, 36 per cent between 20 and 24 years of age, and 37 per cent were aged 25 and over. Oral contraceptives were chosen by 71 per cent of the patients served, intrauterine devices by 10 per cent and other methods by 19 per cent.

CERVICAL CANCER SCREENING PROGRAM

During fiscal year 1973, the Statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Human Resources provided 90,993 Pap smears to indigent and medically indigent patients receiving health services from local health clinics. Since the beginning of the program in 1967, 313,448 Pap smears have been done, and a diagnosis of malignancy has been made in 576 cases. Eighty-eight per cent of the malignancies were preinvasive carcinoma of the cervix. Treatment of diagnosed cases has been provided by state assisted tumor clinics and by private physicians.

NUTRITION

The primary responsibility of the two maternal nutrition consultants is to plan, implement, and evaluate the nutrition component of statewide Maternal Health Program, and provide consultative services through inservice training programs.

Emphasis has been focused on the Special Supplemental Food Program for Women, Infants, and Children (WIC), a Federal program, established to meet the need of essential nutrients during the periods of most rapid growth (pregnancy, infancy, early childhood). Undernutrition imposed at the time of these fast-growing periods can cause deleterious effects of both physical and mental development.

Georgia's eight WIC project sites include 27 counties which serve approximately 8,000 pregnant women, infants, and children per month. This caseload represents only 2 per cent of the target population that is vulnerable to malnutrition. A plan has been designed to increase this caseload by developing and implementing a statewide WIC Program.

The WIC participant receives a food coupon booklet monthly from the Clinic Project site. These coupons which list specific foods as infant formulas, cereals, milk, fruit juices and eggs are redeemed through regular retail grocery stores or dairies.

The Committee applauds the development of a Health Service Research and Statistics Unit in the Division of Physical Health of DHR, which has begun to report on data from birth and death certificates. Dr. Devers of this unit made a special report to the Committee and will have available data useful to health planners and providers of health care and to the business community.

The Committee supports improvement in insurance coverage for obstetric patients.

RECOMMENDATIONS

1. That MAG support continued development of

programs improving maternal and infant health care in Georgia.

2. That MAG support continuing development of regionalization of care for high risk mothers.

3. That MAG support continuing development of regionalization of care for high risk premature and newborn infants.

4. That MAG support the request to the legislature of the Georgia Council on Maternal and Infant Health for funds for care of indigent and medically indigent mothers and infants in Georgia (MAT-PAK).

5. That MAG support improvement in insurance coverage for obstetric care.

6. That MAG be aware of the large numbers of adolescent pregnancies, and that members of MAG attempt to reduce these by family planning, sex education in the schools and all appropriate means.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee wishes to commend the Committee for its outstanding and painstaking work in studying the various aspects of maternal and infant welfare in Georgia.

Recommendation 1 calls for continuing MAG support for the development of programs improving maternal and infant welfare.

Mr. Speaker, your Reference Committee recommends the approval of Recommendation 1.

With regard to Recommendations 2 and 3, which deal with the regionalization of care for high risk mothers and high risk premature and newborn infants, the committee is of the opinion that the concept of regionalization is still vague and inadequately understood. It, therefore, recommends that both Recommendations 2 and 3 be amended to read "that the Medical Association of Georgia *investigate* development of regional care. . . ."

Mr. Speaker, your Reference Committee recommends approval of Recommendations 2 and 3 as amended.

Recommendations 4 and 5 call for the Medical Association of Georgia to support the Georgia MAT-PAK funding program for indigents and to support the improvement in insurance coverage for obstetric care.

Mr. Speaker, your Reference Committee recommends approval of Recommendations 4 and 5.

Recommendation 6 calls for the Medical Association of Georgia to attempt to reduce adolescent pregnancies through family planning and sex education in the schools.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 6.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Maternal and Infant Welfare as amended by the Reference Committee.

COMMITTEE ON PUBLIC HEALTH

J. Gary Palmer, M.D.

The Committee on Public Health met on three occasions during 1974. A fourth scheduled meeting, however, was attended by only one member, and the meeting was unproductive.

The Committee has proceeded with developing educational materials for distribution to MAG members. These include a brochure outlining the procurement of diagnostic materials as well as the location and telephone numbers of district health departments. In addition to this, 3 x 5 cards containing the latest approved treatment schedules are included. These cards contain dosage schedules of various drugs for treatment of both syphilis and gonorrhea. These materials are currently being printed and should be ready for mailing this spring. By supplying this information to each physician we hope to generate a renewed interest in reporting venereal disease as well as the use of proper diagnostic and therapeutic techniques.

A program with public education is currently in production. Thirty-second audio and video tapes are being produced which will be distributed statewide to radio and television stations. Hopefully, these will be aired as a public service feature in all areas. Production of these should be completed in February or March for distribution at that time.

The committee has also approved the production of table top displays showing diagnostic techniques. These displays would graphically show the proper use of Thayer-Martin and Transgrow bottles for gonorrhea culture. Also included would be brochures on syphilis and gonorrhea more detailed than the material mailed to physicians. The purpose of this display would be to set these up at county or district medical society meetings as part of a scientific exhibit. These displays are being developed with the help of the Georgia Department of Human Resources.

We feel that there is a need for nonscientific displays showing the dangers of venereal disease as well as availability of treatment measures. Some type of display should be developed using visual, audio visual and graphic materials, etc. which would be mobile enough to reach shopping centers, high school and college campuses, etc.

Developing such a program as this would be time consuming and require considerable technical assistance. Additional health problems could be brought to the attention of the public by changing the content of these displays. Hopefully, the House of Delegates would authorize the Public Health Committee to proceed with these plans.

RECOMMENDATIONS

1. Continue with the production and distribution of radio and TV spots regarding venereal disease.

2. Continue with production and distribution of physician educational materials.

3. Continue development of visual displays to be shown at various scientific meetings.

4. Develop methods of public education designed to reach high-incident age groups.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee is impressed with the efforts of the Committee on Public Health to educate the public in the matter of venereal disease. The Committee makes specific recommendations to continue with this laudable effort.

Mr. Speaker, your Reference Committee recommends approval of all four recommendations.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Public Health.

AD HOC COMMITTEE TO STUDY PHYSICIANS' ASSISTANTS

John P. Wilson, M.D.

The Ad Hoc Committee to Study Physicians' Assistants was formed by the 1974 House of Delegates at President Bohler's recommendation. As stated in the recommendations the committee's mission is to investigate the new, controversial allied health field of physicians' assistants. The committee consists of eight regular members, three of whom employ physicians' assistants, and one of whom is the Executive Director of the Composite State Board of Medical Examiners. The committee recommended the appointment of the following ex-officio members: The six members of the Physician Assistant Evaluation Agency of the State Board of Medical Examiners, the two directors of PA programs in the state (Medical College of Georgia and Emory), and one hospital administrator, who would provide a liaison with the Georgia Hospital Association.

At its first meeting the committee determined that its mission was not only to do a survey study of PAs, but to address many questions and problems regarding PAs on a long-range basis. The following key problem areas were defined as the committee's chief concern for discussion and action:

1. The quality of the PA's training.
2. A testing mechanism for assuring the competence of PAs.
3. Continuing quality control of PAs (the drawing up of model job descriptions for the various kinds of PAs).
4. Quality control of physicians employing PAs.
5. Liaison between physicians and PA training programs.
6. The relation between PAs and other health personnel, especially nurses.
7. Identification of the PA: Introduction of the PA to the community and hospital and explanation of the PA's role to hospital personnel and other physicians.
8. The problem of PA preceptorships and the limitations that should be put upon them.
9. The accommodation of PAs in hospitals through changes in hospital bylaws.

RECOMMENDATIONS

1. That the committee's status be changed from an Ad Hoc Committee to a Special Committee because of the ongoing and long-range nature of the special problems relating to PAs which the committee will continue to study.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee read this report with great interest and after a lively discussion of problems related to the training and utilization of physician's assistants has reached the conclusion that the committee's present status as an Ad Hoc Committee is appropriate insofar as the work of the committee pertains to one specific area and is not yet finished.

Mr. Speaker, your Reference Committee recommends that the recommendation be not approved, and that the Committee on Physicians' Assistants continue its work in its status as an ad hoc committee.

HOUSE OF DELEGATES ACTION—The recommendation of the Ad Hoc Committee to Study Physicians' Assistants was not approved.

AD HOC COMMITTEE ON LABORATORY QUALITY

G. Lester Forbes, Jr., M.D.

The Ad Hoc Committee on Laboratory Quality was appointed by the Executive Committee to study proficiency testing programs for laboratories in physicians' offices. This has special impact since the State of Georgia currently has under consideration a bill to amend the present Clinical Laboratory Licensure Law. This legislation, if passed, would remove the exemption clause for physicians' offices. In addition, the Medicare-Medicaid regulations contain the means by which a physician can be required to prove the quality of care in his office. This would mean entering into a proficiency testing program, probably not one of the physicians' choice, in order to prove that his laboratory tests were accurate and precise.

It is the opinion of the committee that legislation and implementation of Medicare regulations may be avoided if the Medical Association of Georgia developed a voluntary program of proficiency testing. The committee recommends that the Medical Association of Georgia utilize MLE (Medical Laboratory Evaluation), a proficiency testing program of the American Society of Internal Medicine. This program quarterly sends laboratory specimens of unknown values. A computer printout of results is provided after each testing. The MAG would act as an intermediary in obtaining subscriptions, collecting fees, and monitoring the results of the program.

RECOMMENDATIONS

1. That the Medical Association of Georgia accept the responsibility of developing and monitoring a voluntary program of proficiency testing of physicians' laboratories in the state untilizing Medical Laboratory Evaluation, a proficiency testing program of the American Society of Internal Medicine.
2. That the Medical Association of Georgia make its intention to establish a voluntary program known to the State of Georgia in order to prevent legislation amending the current Clinical Laboratory Licensure Law.
3. Since the Georgia Society of Internal Medicine and the Georgia Academy of Family Physicians will be most affected by this program, that they actively participate in the development of this program.

REFERENCE COMMITTEE RECOMMENDATION—Recommendation 1 calls for the Medical Association of Georgia to take responsibility for quality control of physicians' laboratories, utilizing the program of the American Society of Internal Medicine. Your Reference Committee wishes to amend the recommendation by adding the phrase "or any other acceptable program."

Mr. Speaker, your Reference Committee recommends approval of Recommendation 1 as amended.

Recommendation 2 calls for the MAG to publicize its intent to establish the preceding in order to prevent onerous legislation.

Mr. Speaker, your Reference Committee recom-

mends approval of Recommendation 2.

Recommendation 3 encourages the Georgia Society of Internal Medicine and the Georgia Academy of Family Physicians to participate actively in the program.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 3.

HOUSE OF DELEGATES ACTION—A floor amendment was offered and adopted which substituted the word "assurance" for the word "control" in the recommendation made by the Reference Committee. Following adoption of that amendment, the House adopted the report of the Ad Hoc Committee on Laboratory Quality as amended by the Reference Committee on the floor.

RESOLUTION 7-75
ADEQUATE TRAINING IN GERIATRIC MEDICINE

Delegation of Medical Association of Atlanta

WHEREAS, the failure of residency programs to include adequate training in geriatric medicine is to be deplored; therefore be it

RESOLVED, that the Medical Association of Georgia call for an increased effort to train physicians in geriatrics; and be it further

RESOLVED, that the Medical Association of Georgia explore with appropriate specialty groups ways in which geriatric medicine can be incorporated into residency programs in family practice, internal medicine and psychiatry; and be it further

RESOLVED, that programs in geriatric medicine be included in containuing medical education curricula at the state level.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 7 alleges a deplorable state in the training in geriatric medicine and calls for appropriate improvements to be made.

The Reference Committee agrees with testimony it heard to the effect that there are good training programs in geriatric medicine in the state.

Mr. Speaker, your Reference Committee recommends that Resolution 7 be not approved.

HOUSE OF DELEGATES ACTION—Resolution 7-75 was not approved.

RESOLUTION 8-75
MAG SUPPORT OF AMERICAN TRAUMA SOCIETY

M. A. Glucksman, M.D., Delegate, Glynn County Medical Society

WHEREAS, the American Trauma Society was founded upon recommendation of the National Academy of Sciences and the National Research Council and is endorsed by the American Medical Association, the American College of Surgeons, the American College of Orthopaedic Surgeons, and other national medical organizations; and

WHEREAS, the American Trauma Society strives to bring together physicians, the ambulance profession, the insurance industry, safety engineers, public health officials, the law enforcement and fire protection professions, and others, in an effort to reduce the incidence of accidents and to provide improved services to the victims of accidents and other emergencies; and

WHEREAS, a Georgia Chapter of the American Trauma Society has been established; now therefore be it

RESOLVED, that the Medical Association of Georgia expresses its approval and support of the purposes of the said American Trauma Society and its Georgia Chapter; and be it further

RESOLVED, that the Medical Association of Georgia encourage all physicians involved in the treatment of trauma to inform themselves of the programs and activities of the said American Trauma Society and its Georgia Chapter.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee is in agreement with the general goals and work of the American Trauma Society.

Mr. Speaker, your Reference Committee recommends approval of Resolution 8.

HOUSE OF DELEGATES ACTION—Adopted Resolution 8-75.

Chairman Bailey expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the report of Reference Committee C be adopted as a whole as amended. This motion was duly seconded and approved.



Reference Committee D

REPORT OF REFERENCE COMMITTEE D

H. Hilt Hammett, M.D., Chairman

Chairman Hammett reported to the House of Delegates that the reports and resolutions referred to Reference Committee D had been considered by the committee which met at 1:30 p.m. in the Safari

Room, Fairmont Colony Square Hotel, Atlanta, Georgia, on April 18, 1975. Members of the committee present included H. Hilt Hammett, M.D., LaGrange, Chairman; Jasper T. Hogan, M.D., Macon, Vice Chairman; Harvey M. Newman, M.D., Gainesville; Joseph S. Wilson, M.D., Atlanta; Robley D. Smith, M.D., Tifton.

CHAIRMAN OF COUNCIL

Fleming L. Jolley, M.D.

(For full text of Chairman of Council's report, see reports referred to Reference Committee A. Recommendation 1 was considered by Reference Committee D.)

RECOMMENDATION

1. That the House of Delegates continue to refer significant recommendations to Council for proper implementation.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed Recommendation 1 and unanimously agreed that Council should be referred significant recommendations by the House of Delegates for proper implementation and direction to MAG Committees.

Mr. Speaker, your Committee recommends that Recommendation 1 of the Annual Report of the Chairman of Council be approved.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 of the report of the Chairman of Council.

COMMITTEE ON QUACKERY

James A. Kaufmann, M.D.

Your Committee on Quackery is becoming more and more active as new non-medical cults appear which endanger the health of all Georgians.

The chiropractic profession still reigns as the number one priority with the Quackery Committee. The number of chiropractors licensed to practice in Georgia is continually growing. The construction of the new chiropractic college (Life Chiropractic College in Marietta) will probably produce even more chiropractors who will eventually practice in Georgia thus increasing the danger of Georgia's citizens being subjected to the chiropractic cult.

Many efforts were made on behalf of this committee to block the establishment and opening of this college. However, to start a chiropractic college all one needs to do is get the approval of the Chiropractic Board of Examiners; it is not necessary to meet *any* requirements of the Education Board or any licensing or accrediting agency of state or federal government.

The growing use of "staple puncture" presented the Quackery Committee with some strange and amusing problems during the past year. Through many communications with the Board of Medical Examiners those persons we knew were practicing staple puncture in Georgia were informed they could not do so and either ceased this practice or moved to another state where they could continue to use it.

Other problem areas which are growing and which will continue to grow if not stopped by the efforts of MAG and its Quackery Committee are hair analysis, hypnosis, foot massage and many others.

Your Quackery Committee communicated not only with Georgia physicians but with members of the press and members of the Georgia Legislature informing them of the hazards of such cults and the dangers they present to all Georgians who need quality health care.

RECOMMENDATIONS

Your committee recommends that the Committee on Quackery be continued and that it continue to lead the entire medical profession in efforts to combat the spread of chiropractic and all other non-medical cults.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed the Report of the Committee on Quackery and heard numerous comments from attendants not only of the Committee members, but guests as to the information provided in this report. They were not aware of the chiropractic college now existing in Georgia, the expanded use of staple puncture, foot massage or other non-medical cults. Your Reference Committee recommends the approval of this report with high commendation and praise to Dr. James Kaufmann for his untiring efforts to rid Georgia of these cults. Your Reference Committee unanimously agreed that the Quackery Committee continue to expend its efforts to limit the activities of these non-medical cults in Georgia.

Mr. Speaker, your Committee recommends the approval of the recommendations of the Committee on Quackery.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Quackery.

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. George I. Harrison, President

(Recommendations 1 and 2 of the Woman's Auxiliary to MAG report were considered by Reference Committee D.)

This year the Woman's Auxiliary to the Medical Association of Georgia has emphasized that each auxiliary should select the projects that have the highest priority for their community. The constituent auxiliaries have worked in a great variety of fields ranging from sponsoring courses on Dainty Mechanics to working in immunization and hypertension detection clinics. We have worked in Health Education, Family and Community Health, Mental Health, Children and Youth and International Health.

Dr. James Manning has served as chairman of the Advisory Committee and we shall be forever grateful for the guidance and support he has given us throughout the year. The staff of MAG Headquarters has been most helpful.

The Auxiliary now counts slightly more than 2,500 members in 37 counties. We are continuing our efforts to increase membership and form new auxiliaries. We have strived this year to reach new levels of fiscal responsibility providing our members with the same quality service at a reduced cost.

The Auxiliary has continued to operate the Allied

Medical Careers Office. The county groups have sponsored many career days from high school students and have given scholarships to students interested in pursuing paramedical careers. Aid has also been given to nursing education programs in junior colleges.

Georgia has been represented at all important national and regional meetings.

We continue to support the William R. Dancy, M.D. Student Loan Fund. Contributions from 10 auxiliaries this year of $827 brought the total value of the fund to $54,806.28. Four new loans were granted this year.

Auxiliary contributions to AMA-ERF have reached $8,500. We are confident that by the end of the year they will match or exceed last year's contributions.

The auxiliary members have become increasingly aware of the need to be knowledgeable about medical legislation. Time has been devoted to this field at our state meetings and many counties report to their members on current legislative developments at each meeting.

RECOMMENDATIONS

1. The Auxiliary Legislation Chairman be invited to attend meetings of the MAG Legislative Committee.
2. The Auxiliary Legislative Chairman be invited to meeting of the GaMPAC Board.
3. MAG shall collect Auxiliary membership dues at such time as MAG adopts a centralized, computerized billing system with all component societies participating.
4. The Auxiliary be permitted to arrange for the publication of our directory with MAG monetary support.
5. The Auxiliary be permitted to disburse the funds allocated by MAG for Auxiliary convention expenses.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee listened with interest and concern to the deliberations of this report. Your Committee recognizes the ever-increasing need for the Woman's Auxiliary involvement in all aspects of MAG. The Auxiliary's participation is an untapped resource which the Medical Association of Georgia can better utilize in the future. The Woman's Auxiliary now has an active and functioning Legislative Committee and it is the opinion of the Reference Committee that their Chairman should be invited to attend meetings of the MAG Legislative Committee.

Mr. Speaker, your Committee recommends that Recommendation 1 of the Report of the Woman's Auxiliary to the Medical Association of Georgia be approved.

Your Reference Committee listened to the wishes of the Woman's Auxiliary concerning the Legislative Chairman being invited to the meetings of the GaMPAC Board and also reviewed the Bylaws of GaMPAC which specifically state that there shall be an Auxiliary co-chairman for each congressional district in Georgia. It was brought to this Reference Committee's attention that the co-chairman of GaMPAC for Women's Activities is charged with the duty to select and recommend to Council for approval a co-chairman for each congressional district. This will allow the Woman's Auxiliary participation in the functions of the GaMPAC Board.

Mr. Speaker, your Committee therefore recommends that Recommendation 2 be disapproved.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 of the report of the Woman's Auxiliary and disapproved Recommendation 2.

RESOLUTION 4-75

CREATION OF SPECIAL COMMITTEE ON GOVERNMENTAL HEALTH PROGRAMS

John M. Martin, M.D., Delegate,
Richmond County Medical Society

WHEREAS, governmental health programs are becoming more numerous each year and,

WHEREAS, impending legislation instituting some form or forms of national health insurance seems simply a matter of time and,

WHEREAS, the Medical Association of Georgia will continue to be involved with such programs in the future and,

WHEREAS, members of the Medical Association of Georgia need to be kept abreast of the Association's activities as they relate to Federal and State health programs and,

WHEREAS, no specific committee for dealing with matters relating to Federal and State Governmental health programs in general now exists, be it therefore

RESOLVED, that the Medical Association of Georgia form a standing Committee on Governmental Health Programs which would serve the membership, the Council, and the Executive Committee of Council in keeping the Association informed on such health programs, and could aid in resolving problems arising between members of the Association and carriers who administer such health programs. Obviously, this Committee would work closely with other related Committees already in existence.

Adopted this 25th day of February, 1975.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed and agreed with the resolution for the need for a Committee on Governmental Health Programs. This Committee was informed of a newly appointed MAG Committee on Third-Party Relations recently established. Your Committee agreed that this Committee on Third-Party Relations would overlap in many areas with a Committee on Governmental Health Programs. For this reason, your Reference Committee believes MAG Council can best determine in the near future if the need for a separate Committee on Governmental Health Programs should be established.

Mr. Speaker, your Committee recommends that Resolution 4-75 be referred to Council.

HOUSE OF DELEGATES ACTION—Referred Resolution 4-75 to Council.

RICHMOND COUNTY MEDICAL SOCIETY COUNCILOR

Ronald F. Galloway, M.D.

It has been a pleasure serving another year as Councilor to the Medical Association of Georgia from Richmond County. Either Dr. Scoggins or myself have attended each Council meeting during the year. This

year, I have two specific recommendations. Each of these two recommendations are based on the fact that, during the year, the Council of the Medical Association of Georgia has the responsibility for carrying on the business of the Association which might otherwise be conducted by the House of Delegates during the Annual Sessions. This, therefore, is a tremendous responsibility on Council and it is hoped that my two recommendations will enable Council to do its work more efficiently.

RECOMMENDATIONS

1. Items to be discussed at Council meetings which involve complicated and/or detailed reports should be discussed only after information pertinent to these items has been made available to the Council members at least 10 days to two weeks before the date of Council meetings. Too frequently, bulky and complicated items are tossed in the lap of Council to be decided on a "spur of the moment" basis. This is inefficient and is due to lead to errors in decision on the part of Council.

2. Many items are discussed at considerable length at Council meeting which would be better handled by one of the many committees of the Medical Association of Georgia before being presented to the Council for final action. More efficient use of the Committee structure of the Medical Association of Georgia would, in my opinion, allow Council to act on the recommendations of its various committees.

MEMBERSHIP

County and Secretary	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Richmond				
Jimpsey B. Johnson				
Augusta	311	270	305	283

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed and had considerable deliberations on Recommendation 1 of this report. It is the consensus of this Reference Committee that if Recommendation 1 is approved, it could possibly limit the agenda of Council meetings to only such pertinent information that was made available at least 10 days to two weeks before the Council meetings. We all know that at certain times important reports and information are presented to the Council on short notice. There needs to be an appropriate means to determine if this information should be reviewed at the next Council meeting. This Reference Committee was informed that the present rule of the MAG Council is that all resumes and information to be considered by the Council have to be sent to the Council members at least two weeks before they meet or, in order to be on the Council agenda, the other individual items have to be personally approved by the Chairman of Council. This Reference Committee feels that this is appropriate, and accordingly, recommends that Recommendation 1 of the Annual Report of the Councilor of the Richmond County Medical Society be disapproved.

In consideration of Recommendation 2, your Committee agrees that numerous reports now being proposed directly to Council can be deliberated, eliminated and/or perfected in already standing committee of the Medical Association of Georgia. If this were utilized to the extent possible, there could be more efficient use of the committee structure, therefore, much of the deliberations now being heard before Council could be deleted. In view of this,

Mr. Speaker, your Committee recommends approval of Recommendation 2 of the Annual Report of the Councilor of the Richmond County Medical Society.

HOUSE OF DELEGATES ACTION—Disapproved Recommendation 1 of the report of the Richmond County Councilor and adopted Recommendation 2.

SEVENTH DISTRICT COUNCILOR

Don Schmidt, M.D.

It has been a great pleasure for me to serve the Seventh District as Councilor. I see the following problems as a great challenge to the Medical Association of Georgia. With the many problems that we face in the future the communications between Council and each constituent county medical society must be improved. I feel that the average member of the Medical Association of Georgia needs to be more aware of the tremendous problems that involve our Association. This needs to be done in order to get a greater input as to their opinions and ideas rather than their criticism as one on the outside. I feel that the idea that the Council of the Medical Association of Georgia will have to be reorganized is a start. I think this will have to come about as the problems that are faced require more debate and deep consideration before any action taken. It will perhaps have to be that the Council or Board of Directors, or which ever it is designated, will have to meet more frequently in order to adequately cover the tremendous amount of work required at each Council meeting. I feel that this is a very pressing problem and although we are very fortunate in having very dedicated members of Council, I believe that the size and structure needs to be streamlined and meet more regularly.

Inflation will continue to be a great challenge. I believe that through our representatives to the AMA we must persist in insisting upon economy in operation because there was a great deal of discontent expressed to me when the proposed AMA dues increase to $200 was considered. The Medical Association of Georgia must persist in its move for economy and in a like manner insist that the AMA do the same.

The Insurance Committee of the Medical Association of Georgia has done an outstanding job but the problem of malpractice insurance is going to challenge the medical profession to its fullest. It is hoped that through legislation and the continued dedicated work of our insurance committee, Council, the House of Delegates, and every member of the MAG that this problem will be satisfactorily met.

I look forward to my next two years on the Council of MAG and will do all in my power to make a constructive contribution to the governing of our great Association.

RECOMMENDATION

1. I would like for this report to be considered in its

entirety by a reference committee.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying Only
Bartow				
Virginia D. Hamilton				
Cartersville	11	6	8	6
Carroll-Douglas-Haralson				
Curtis Batchelor				
Bremen	36	33	35	32
Floyd-Polk-Chattooga				
Eduardo Montana				
Rome	93	70	100	80
Gordon				
Frank Alvarez				
Calhoun	11	10	9	9
Walker-Catoosa-Dade				
Murphy K. Cureton				
LaFayette	36	21	39	23
Whitfield-Murray				
Paul L. Bradley				
Dalton	56	45	55	48
	243	185	246	198

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee reviewed this report and appreciates the time and effort that Dr. Don Schmidt devoted to its preparation. Your committee would like to commend Dr. Schmidt for his efforts and acknowledges the appreciation MAG has for reports of this caliber.

Mr. Speaker, your Committee recommends approval of Recommendation 1 of the Annual Report of the Councilor of the Seventh District.

HOUSE OF DELEGATES ACTION—Adopted the report of the Seventh District Councilor.

RESOLUTION 2-75 PROFESSIONAL LIABILITY

James C. Dudley, M.D., for Sumter County Medical Society

WHEREAS, the increasing number of medical malpractice suits are causing premiums for professional liability insurance to increase at an alarming rate; and

WHEREAS, the cost of liability insurance tends to raise the cost of medical care of patients therefore be it,

RESOLVED that the MAG go on record favoring the elimination of contingency fees for attorneys in malpractice litigations, and be it further

RESOLVED that the MAG favors a panel of qualified members of the medical and legal professions rather than a regular jury in medical malpractice litigation and be it further

RESOLVED that MAG submit a similar resolution to the AMA seeking their support in obtaining suitable federal legislation to accomplish these proposed changes in the judicial process.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee heard numerous testimonies as to the problems of professional liability and possible solutions of their own. The ever-growing problem of professional liability is one in which all MAG members are *vitally* concerned. The Medical Association of Georgia has an Insurance and Economics Committee which for many months has been studying and acquiring information as to the problems of professional liability.

Reported in the minutes of the Insurance and Economics Committee's report to Council, April 17, 1975, under the subheading "Legislative Proposals," the Committee agreed to formulate and submit to the MAG Legislative Committee within 60 days adequate proposals for possible legislative implementation of legislation to ease the professional liability problem which now exists in Georgia. Due to the complexity of the problem and the time the Insurance and Economics Committee has spent studying this problem, your Reference Committee unanimously feels that this resolution should be referred to the Insurance and Economics Committee. We feel that the knowledge and expertise that this commitee is acquiring is more suitable to deliberate not only the possibility of implementing this resolution, but also the effect of such proposed changes; therefore,

Mr. Speaker, your Committee recommends that Resolution 2-75 be referred with priority request to the Insurance and Economics Committee.

HOUSE OF DELEGATES ACTION—Referred Resolution 2-75 to the Insurance and Economics Committee with request for priority consideration.

COMMITTEE ON INSURANCE AND ECONOMICS

William W. Moore, Jr., M.D.

The Insurance and Economics Committee has been very active in the 1974-1975 fiscal year.

The professional liability problem is foremost in our thoughts. Our carrier, The St. Paul Companies, has announced their intention to change to a "claims made" policy on a nationwide basis in an earnest endeavor to remain a carrier in the professional liability field.

The number of major companies still offering professional liability coverage has shrunk from 25 in April 1974, to 6 in April 1975. We feel that in a sense Georgia is fortunate in that we are one of eight program states with St. Paul, which means we are one of eight out of all 50 in which St. Paul will write new business, that is, cover new graduates coming out of medical school and beginning the practice of medicine.

"Claims made" has its disadvantages. It does not automatically cover the "long tail" liability, and it does mean paying three additional years premium after retirement, disability, or untimely death. Your committee is working with St. Paul and other carriers to come up with an annuity plan to cover these unknown premiums for these added years, and we have a ruling from our attorney that such premiums will be tax deductible.

Claims made contracts will continue to cover you just as you are covered now so long as you renew your policies and remain in practice in the State of Georgia. Your premium will be based on the current year costs to the insuror, plus an estimate for just one additional year.

St. Paul has advised us that they will write only $1,000,000 in umbrella or "top brass" coverage when

your present policy expires. Other insurors are being sought to carry larger amounts for those physicians desiring higher coverage.

By the time of the Annual Session, rates should be available from St. Paul. The committee has recommended to the Executive Committee that this change to "claims made" be accepted. There is very little alternative.

REFERENCE COMMITTEE RECOMMENDATION —Your Committee reviewed this report and the multi-page report of the Insurance and Economics Committee presented to Council in its entirety. Your Reference Committee would like to amend Report C: 15-75 by striking the last sentence of the seventh paragraph and adding an additional paragraph which reads as follows:

"This House of Delegates should deplore the fact that the only professional liability insurance available to physicians in Georgia will be on 'claims-made' basis.

"Subsequently, this Reference Committee recommends that both the Insurance and Economics Committee and the Council of MAG pursue every reasonable means to obtain a more desirable type of professional liability coverage."

With this amendment, your Commitee unanimously approves with commendation the Annual Report of the Committee on Insurance and Economics; therefore

Mr. Speaker, your Committee recommends the approval of Annual Report of the Committee on Insurance and economics as amended.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Insurance and Economics as amended by the Reference Committee.

SECRETARY

Earnest C. Atkins, M.D.

Recommendation 5 of the report of the Secretary deals with state-level unified membership and was considered along with item 4 in the report of the Committee on Constitution and Bylaws. (See Constitution and Bylaws report in this Reference Committee.)

BIBB COUNTY MEDICAL SOCIETY COUNCILOR

Milton I. Johnson, Jr., M.D.

Recommendation 5 of the report of the Bibb County Councilor addresses the abolishment of the office of Vice Councilor. This same subject is dealt with in detail in the report of the Ad Hoc Committee on Organization and Functions and, accordingly, the two reports are considered together under the heading of "Organization and Functions Committee Report." (See Organization and Functions Committee report in this Reference Committee.)

COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin, M.D.

ITEM 1: Representative from each chapter of the Student American Medical Association as voting members of the House of Delegates.

Council approved the submission to the House of Delegates of an amendment to Article V, Section 1, of the Constitution allowing one representative from each chapter of the Student American Medical Association to be a voting member of the House of Delegates.

Specifically, it is recommended that Article V, Section 1, be amended by striking the first sentence in its entirety and substituting in lieu thereof the following:

"The House of Delegates is composed of delegates elected by the component county medical societies and one representative elected by each chapter of the Student American Medical Association in the state of Georgia as provided for in the Bylaws." Said section would then read as follows:

"The House of Delegates is composed of delegates elected by the component county medical societies and one representative elected by each chapter of the Student American Medical Association in the state of Georgia as provided for in the Bylaws. The officers, the Past Presidents of the Association, the Editor of the *Journal,* delegates to the AMA, the Executive Director and Chairmen of standing committees shall be ex-officio members of the House of Delegates without the right to vote."

ITEM 2: Secretaries of county medical societies certifying delegates.

The following amendment is offered in response to a request by Executive Committee, which was approved by Council, to empower the secretaries of the county medical societies, in addition to the presidents, to certify delegates in the absence of the regular delegate and alternate delegate.

Chapter VII, Section 7, Delegates, is hereby amended by deleting the last sentence of said section in its entirety and inserting in lieu thereof the following:

"In the absence of, or the disability or disqualification of a delegate, the vacancy may be filled by the president *or the secretary* of the society from other members of the same component society."

Said section would then read as follows:

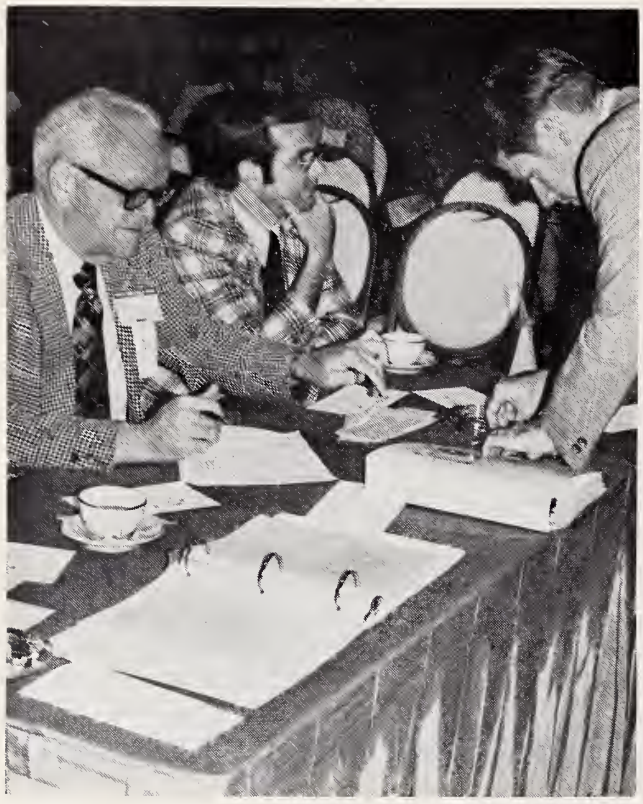
"SECTION 7. Delegates. Each component county society shall elect prior to February 1st delegates and alternates to the House of Delegates in accordance with these Bylaws. The Secretary of each component society shall send a list of such delegates to the Secretary of the Association before February 1st. In the absence of, or the disability or disqualification of a delegate, the vacancy may be filled by the President or the Secretary of the society from other members of the same component society."

ITEM 3: Bylaws change requiring that the Chairman of Council be a member of Council.

The following amendment is offered in response to a request by Executive Committee, which was approved by Council, to require that the Chairman of Council be elected from among the membership of the Council.

Chapter IV, Section 2, is hereby amended by deleting said section in its entirety and inserting in lieu thereof a new Section 2 as follows:

"**Section 2. Chairman and Secretary.** A Chairman and a Vice-Chairman of Council shall be elected annually *by the Council and shall be chosen from among*



Delegates pause at the desk of the Credentials Committee as each of House Delegates session begins to check in with staff member L. B. Storey and John G. Forshner M.D. of Dalton.

the Councilors. Their election shall take place at the organizational meeting and they shall serve for one year, or until their successors are elected. The Chairman or Vice-Chairman shall preside over meetings of Council and shall appoint all necessary committees of Council. The Secretary of the Association shall serve as Secretary of Council. The Council may designate the Executive Director or Associate Director to serve in this capacity."

ITEM 4: Unified membership at the state and county levels.

The Executive Committee instructed the committee to prepare language requiring MAG membership as a condition for membership in a county medical society. This language, although disapproved by Council, is hereby submitted for approval of the House of Delegates.

Chapter VII, Section 1, is hereby amended by adding the following sentence at the end of said Section 1:

"No person may be admitted to or maintain membership in a component society unless that person is also a member in good standing of the Medical Association of Georgia."

ITEM 5: Reinstatement of delinquent members.

The 1974 House of Delegates also instructed the Constitution and Bylaws Committee to draft language allowing reinstatement of delinquent members upon payment of the current year's dues and approval of his county medical society.

Chapter VIII, Section 2(A)(3) is hereby amended by deletion in its entirety and by substituting in lieu thereof the following:

"(3) An active member who fails to pay dues (or additional dues) for one or more years shall be eligible for reinstatement upon payment of dues for the current year subject to reapplication and approval of his county medical society."

(January 11-12, 1975—approved by Council.)

ITEM 6: Expansion of MAG purposes.

The 1974 House of Delegates asked the Constitution and Bylaws Committee to prepare language to expand the purposes of the Association by incorporating into the Constitution and Bylaws the recommendations from the 1974 Annual Report of the Ad Hoc Committee on Organization and Functions. This requires both Constitution and Bylaws changes.

Article II of the Constitution is hereby amended by adding to said article the words, "as provided for in the Bylaws," so when amended Article II will then read:

"The purposes of the Association are to promote the science and art of medicine and the betterment of public health as provided for in the Bylaws."

Chapter I of the Bylaws is hereby amended by inserting a new Chapter I as follows and by renumbering the current Chapter I, Membership, as Chapter II, Membership, and renumbering of all subsequent chapters accordingly.

"Section 1. The purposes of the Association as specified in the Constitution shall be met in the following ways:

(a) Establish the federation of organized medicine through the chartering of constituent county medical societies in Georgia and, by joining with similar state medical associations, constitute the American Medical Association.

(b) Promote the provision of quality medical care at reasonable cost with fair remuneration to the physician.

(c) Encourage the maintenance of the physician-patient relationship as an essential in the delivery of quality medical care.

(d) Seek to assure all Georgians access to quality medical services regardless of their financial condition, geographic location or sophistication in using the health care systems.

(e) Advance the scientific, socio-economic and medical-political knowledge of the profession so that the members may better serve their patients, their community and their association.

(f) Maintain the highest standards of professional conduct and adhere to the Principles of Medical Ethics set forth by the AMA.

(g) Support reasonable expansion of the number of persons entering the medical and allied health professions, as well as assure that the best qualified individuals are admitted into the professions in order to meet the established needs for such manpower in Georgia.

(h) Reinforce recognition of an ongoing, life-long need for continuing medical education in the art and science of medicine through participation in programs of continuing education.

(i) Establish and provide specific services to the membership which meet their needs."

(January 11-12, 1975—approved by Council.)

ITEM 7: Finance committee changes.

Based on the 1974 President-Elect's Annual Report, the 1974 House of Delegates directed the committee to draw up language to 1) set a maximum limit for unbudgeted expenditures by Council; 2) reconstitute the

Finance Committee as a committee of the House of Delegates, rather than a committee of the Council; and 3) authorize the House Finance Committee to consider and approve expenditures recommended by Council which are in excess of the limitations set for Council. This would require both Constitution and Bylaws changes and they are now presented for the House of Delegates' approval.

Article VI, Section 2, of the Constitution is hereby amended by deleting the last sentence of said Section 2 and inserting in lieu thereof the following:

"The Council has charge of all property and financial affairs of the Association consistent with the limitations imposed by the Finance Committee of the House of Delegates and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws."

Article X is hereby amended by deleting the last sentence of said Article X in its entirety and substituting in lieu thereof the following:

"The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association consistent with the limitations imposed by the Finance Committee of the House of Delegates."

Chapter III of the Bylaws is hereby amended by adding a new Section 9 as follows:

"There shall be a Committee on Finance which shall be a committee of the House of Delegates. Said committee shall be composed of five active members of the Association, one of whom shall be the Treasurer who will serve ex-officio as Chairman of the committee. Four members of the committee shall be elected annually by the House of Delegates from among those nominated orally on the floor of the House of Delegates. The Committee on Finance shall cause to be audited all accounts of the Association on an annual basis. The committee shall propose an annual budget for the fiscal year beginning June 1 and running through May 31 of the following calendar year. Such budget shall be subject to modification and approval of the Council. Each committee shall submit to the Committee on Finance its budget for the following fiscal year at such time as the Committee on Finance may designate. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting prior to the Annual Session. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Finance.

The Committee on Finance shall consider and may approve requests by Council for expenditures of unbudgeted Association funds in excess of 4 per centum of the annual Association budget. The committee shall act expeditiously on all such requests."

Chapter IV, Section 5, is hereby amended by deleting the period at the end of the first sentence and inserting in lieu thereof a semi-colon followed by the following phrase:

"; provided, however, that the Council shall be limited in its expenditure of unbudgeted Association funds to an amount not to exceed 4 per centum of the current annual budget."

Chapter IV, Section 9, of the Bylaws is hereby amended by deleting said Section 9 in its entirety.

Chapter V, Section 2, is hereby amended by insertion of the phrase "four members of the Committee on Finance" in the last sentence of said section so that when amended Section 2 of Chapter V reads as follows:

"Section 2. Procedure for nominations and election of officers. Nominations for the President-Elect, Second Vice President, Secretary, Treasurer, Delegates and Alternate Delegates to the American Medical Association, Speaker and Vice Speaker of the House of Delegates in years when the predecessors' terms of office are expiring, four members of the Committee on Finance, as well as Councilors and Vice-Councilors with respect to whom notice of election has not been forwarded by the secretary of the electing society to the Secretary of the Association not later than fifteen (15) days before the Annual Session shall be made by members of the House of Delegates orally from the floor at the first meeting thereof occurring in the Annual Session and no nominating or seconding speech shall exceed two minutes. Election of such officers and Finance Committee members shall occur as provided in the House of Delegates' order of business at the last session of the House of Delegates at the Annual Session, such election to be made by the official members of the House of Delegates not including the ex-officio members thereof."

Chapter VIII, Section 1, is hereby amended by adding a new last sentence to said Section 1 as follows:

"The Treasurer shall serve as Chairman of the Committee on Finance of the House of Delegates."

Chapter IX, Section 3, is hereby amended by deleting the parenthetical phrase at the end of said section 3 and inserting in lieu thereof the phrase "(See Chapter III, Section 9)."

Chapter IX, Section 7, is hereby amended by deleting the last word of the last sentence and submitting the words "House of Delegates" so that the last sentence of said section then reads:

"The Committee shall submit a budget for the Annual Session to the Finance Committee of the House of Delegates."

(January 11-12, 1975—approved by Council)

CONSTITUTION AND BYLAWS COMMITTEE OPINION

Your committee strongly disapproves of these amendments for the following reasons:

1. Finance Committee, as a committee of the Council, has worked well for many years and has served the needs of the Association in a most efficient manner.

2. Council is more representative of the physicians of the state than would be a five member Finance Committee and, therefore, better able to reflect the wishes of the membership.

3. The present system is more flexible and, for this reason, in a better position to meet unusual contingencies that may arise.

For these reasons your Committee on Constitution and Bylaws recommends that these amendments be rejected.

ITEM 8: Elect the Speaker and Vice Speaker of the House of Delegates from among the delegates to the House of Delegates.

The following amendment is offered in response to a request by Executive Committee that the Speaker and Vice Speaker of the House of Delegates be chosen from among the delegates. This would require both Constitution and Bylaws changes which are herein offered for the approval of the House of Delegates.

CONSTITUTIONAL AMENDMENT

Amend Article I, Section 4, by deleting from the first sentence thereof the phrase "Speaker of the House of Delegates, Vice Speaker of the House of Delegates," so that when amended said Article IX, Section 4 would read:

"Section 4. Terms of other officers. Other officers shall be elected for terms of one year each except the Secretary, the Treasurer and the Councilors and Vice-Councilors, who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

BYLAWS AMENDMENT

Amend Chapter III, Section 4, of the Bylaws by inserting in the last sentence of said section the following phrase: "and from among" so that the amended Section 4 would then read:

"Section 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice Speaker. In the absence of both, a delegate agreeable to it may preside. The Speaker and Vice Speaker shall be elected annually by *and from among* the members of the House of Delegates."

Amend Chapter III, Section 6, by deleting the parenthetical phrase "(every third year at second session of House of Delegates during Annual Session)" so when amended said Chapter III, Section 6, would read:

"Section 6. The following shall be the general order of business at all meetings of the House of Delegates: (1) call to order by the Speaker; (2) roll call; (3) election of Speaker and Vice Speaker, their terms of office to begin with adjournment of the House of Delegates, provided a Speaker and Vice Speaker be elected as the next order of business after the adoption of this bylaw; (4) reading and adoption of minutes; (5) reports of officers; (6) reports of committees; (7) unfinished business; and (8) new business. At any meeting, the House by majority vote may change the order of business. New business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent."

Amend Chapter VI, Section 6, by deleting from the first sentence thereof the phrase "three years" and inserting in lieu thereof the phrase "one year" so when amended the first sentence of said Section 6 would then read:

"The Speaker of the House of Delegates shall serve for one year after being duly elected by the members of the House of Delegates and he shall preside over all meetings of the House of Delegates."

Chapter VI, Section 7, is amended by deleting from the first sentence of said Section 7 the phrase "three years" and inserting in lieu thereof the phrase "one year" so when amended the first sentence of said Section 7 shall read:

"The Vice Speaker of the House of Delegates shall serve for one year after being duly elected by the members of the House of Delegates and he shall preside over the House of Delegates in the absence of the Speaker."

Amend Chapter V, Section 1, by deleting said Section 1 in its entirety and substituting in lieu thereof the following:

"Section 1. Officers and terms of office. The officers of the Association are the President, President-Elect, two Vice Presidents, the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the Vice Speaker of the House of Delegates and the Councilors and Vice Councilors. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. The Second Vice President shall be elected annually and shall become First Vice President at the time of the next Annual Session. The Speaker of the House of Delegates and the Vice Speaker of the House of Delegates shall be elected annually and their terms of office shall begin with adjournment of the House of Delegates. The Secretary, the Treasurer and the Councilors and Vice Councilors shall serve for terms of three years. Delegates and Alternate Delegates to the American Medical Association shall serve in accordance with the Constitution and Bylaws of the American Medical Association and shall be elected in accordance with the provisions of these Bylaws consistent therewith. All other officers shall serve for one year. No member shall hold the office of Secretary or Treasurer more than two consecutive terms. The Speaker shall have a maximum tenure of six consecutive years."

(January 11-12, 1975—disapproved by Council.)

REFERENCE COMMITTEE RECOMMENDATION —The report of the Constitution and Bylaws Committee was lengthy. Considerable in-depth attention was given to each item addressed in the report.

Item 1 of the report would amend Article V. Section 1, of the Constitution by providing for one representative to the House of Delegates to be elected by each chapter of the Student American Medical Association (name changed to American Medical Student Association) in Georgia. Your Committee heard testimony by three student representatives from Medical College of Georgia and was impressed by the sincerity and candor of their remarks. However, the Committee was reminded of the fact that this same constitutional amendment was turned down by the House of Delegates in 1974 and, while your Committee encourages continued participation in the affairs of MAG by student representatives of AMSA, it nonetheless feels that a vote should not be given to them at this time. Accordingly,

Mr. Speaker, your Committee recommends disapproval of Item 1 in the Report of the Constitution and Bylaws Committee.

Item 2 amends Chapter VII, Section 7, by empowering the Secretary of a county medical society with

the authority to designate a qualified member of his society as an MAG delegate should the elected delegate be absent or unable to serve. At the present time only the county society President has this authority.

Mr. Speaker your Reference Committee recommends approval of Item 2.

Item 3 amends Chapter IV, Section 2, by providing that the Chairman and Vice Chairman of Council should be elected from among the members of Council.

Mr. Speaker, your Committee heard no dissenting testimony on this item and, accordingly, recommends approval.

Item 4 amends Chapter VII, Section 1, of the Bylaws by providing that membership in MAG would be a requirement for membership in a county medical society. This item was considered jointly with Recommendation 5 of the Secretary's Report.

Furthermore, the Reference Committee learned of a special situation which exists in extreme northwest Georgia, which it feels merits special consideration. The Walker-Catoosa-Dade Medical Society has several members who reside in and whose predominate practice is in Tennessee. Each is a member of the Tennessee Medical Association as well as the Hamilton (Tennessee) County Medical Society. Spokesmen for the Walker-Catoosa-Dade Society feel that it would be unrealistic to expect these physicians to belong to two state medical associations. The Reference Committee found this logic convincing.

Another factor that influenced the consideration of the Reference Committee was its review of Article X of the Constitution which currently reads: "Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society." In view of the obvious meaning of this provision of the Constitution, together with the fact that the Committee found itself in agreement with the Report of the Secretary as well as the Report from the Constitution and Bylaws Committee, your Reference Committee recommends that Item 4 be amended as follows:

"No person may be admitted to or maintain membership in a component society unless that person is also a member in good standing of the Medical Association of Georgia; provided, however, that the provision of Chapter VII, Section 1, shall not apply to those physicians who practice and reside in an adjacent state and who are members in good standing of the state medical association in the state of their residency and practice."

Mr. Speaker, your Reference Committee recommends the adoption of Item 4 as amended with the observation that unified membership appears to already be a provision of the MAG Constitution.

Item 5 amends Chapter VII, Section 2(A)(3) of the Bylaws to excuse the payment of dues in arrears as a condition of reinstatement to membership upon payment of dues for the current year and reapplication and approval of his county medical society.

Mr. Speaker, your Committee recommends the adoption of Item 5.

Item 6 amends both the Constitution and the Bylaws so as to expand upon the purposes of the Association. The current purposes of MAG, which are "to promote the science and art of medicine and the betterment of public health," are found in Article II of the Constitution. The proposed expanded purposes are too long for inclusion in the Constitution and are more properly suited to inclusion with the Bylaws. Therefore, a very brief constitutional amendment is required that merely recognizes the expanded purposes by reference as found in the Bylaws; thus preserving the brevity of the Constitution while accomplishing the intent of the amendment.

Your Committee would remind the House that the expanded purposes of the Association were adopted by the 1974 House of Delegates when it approved the report of the Ad Hoc Committee on Organization and Functions.

Inasmuch as this is both an amendment to the Constitution, which must lie on the table for a year, and a Bylaws amendment,

Mr. Speaker, your Committee recommends that the House of Delegates accept Item 6 of the report and thus mark the beginning of the time that it must lay on the table before it can be voted on in 1976.

Item 7 provides for multiple amendments to both the Constitution and to the Bylaws in order to accomplish the following objectives:

A. Terminate the Finance Committee as a Committee of Council and establish it as a Committee of the House of Delegates;

B. Set a maximum limit on the amount of unbudgeted expenditures that may be made by Council;

C. Provide a mechanism through which the House Finance Committee could consider and approve expenditures recommended by Council which exceed the limitations set for Council.

This series of two constitutional amendments and seven bylaws amendments would accomplish the above by establishing a five member House Finance Committee with the elected MAG Treasurer serving as Chairman and the four remaining members elected by the House of Delegates following oral nominations from the floor of the House. These several amendments further provide that Council shall be limited in its expenditures of unbudgeted funds to an amount not to exceed 4 per cent of the budget current at the time of expenditure. The Bylaws are further amended to authorize expenditures that exceed 4 per cent when approved by the Finance Committee.

Following lengthy consideration of this item, your Reference Committee found itself in disagreement with Item 7 for the same reasons that the Constitution and Bylaws Committee also found them to be deficient. These are:

1. The Finance Committee as a Committee of the Council has worked well for many years and has served the needs of the Association in a most efficient manner.

2. Council is more representative of the physicians of the state than would be a five member Finance Committee and, therefore, better able to reflect the wishes of the membership.

3. The present system is more flexible and, for this reason, is in a better position to meet unusual contingencies that may arise.

Mr. Speaker, your Reference Committee recom-

mends that the House not approve Item 7 of the Constitution and Bylaws Committee report.

Item 8 provides for the election of the Speaker and Vice Speaker from among the members of the House of Delegates and further provides that they shall be elected annually. To do this, multiple amendments to the Bylaws plus one Constitutional amendment would be necessary.

The constitutional amendment to Article IX, Section 4, would provide for the annual election of the Speaker and Vice Speaker. The five bylaws amendments provide for the election of the Speaker and Vice Speaker from among the members of the House and otherwise amend the Bylaws to be consistent with the proposed constitutional amendment.

There was general agreement with the concept that the Speaker and Vice Speaker should be elected from among the members of the House. Your Committee, however, feels the recommendation to be deficient, and, accordingly recommends that the House instruct the Constitution and Bylaws Committee to rewrite these amendments to provide that the Speaker and the Vice Speaker shall be members of the House of Delegates, elected for three year terms.

Mr. Speaker, your Reference Committee moves the adoption of the Report of the Constitution and Bylaws Committee as amended.

HOUSE OF DELEGATES ACTION—Item 1 of the report of the Committee on Constitution and Bylaws was disapproved. Item 2 of the report was adopted. Item 3 of the report was adopted. Item 4: Delegate Robert Coggins, Marietta, moved that Item 4 of the Constitution and Bylaws Committee report be tabled until the 1976 Annual Session. (Recommendation 5 of the report of the Secretary related to state-level unified membership and was not adopted.) The tabling motion was seconded and passed by the House of Delegates. Item 5 of the Constitution and Bylaws Committee report was adopted. Item 6 of the report provided language to amend both the Constitution and the Bylaws. The House adopted bylaws amendment and accepted the constitutional amendment to lay on the table to be voted on at the 1976 session. Accordingly, item 6 was adopted by the House. Item 7: Delegate J. Rhodes Haverty moved to amend the report of the Reference Committee by referring item 7 back to the Executive Committee, thence to the Constitution and Bylaws Committee and, subsequently, back to the House of Delegates at the Annual Business Session in 1976. This motion was seconded and passed. Item 8 refers to a constitutional amendment and multiple bylaws amendments. The House voted to refer these back to the Constitution and Bylaws Committee with specific instructions to rewrite the amendments to provide for the election of the Speaker and Vice Speaker for three year terms.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin, M.D.

ITEM 1: Change Emergency Medical Services Committee from a standing committee to a special committee.

The following amendment is offered in response to a request by Executive Committee to change the Emergency Medical Services Committee from its current status as a Standing Committee to that of a Special Committee.

Chapter IX, Section 1, of the Bylaws is hereby amended by deleting subparagraph (G) Committee on Emergency Medical Services.

ITEM 2: Delete reference to number of terms members of Professional Conduct and Medical Ethics Committee may serve.

The following amendment is offered in response to a request by Executive Committee to delete any reference to how many terms a physician may serve on the Professional Conduct and Medical Ethics Committee.

Chapter IX, Section 4, of the Bylaws is hereby amended by deleting from the first paragraph of said section the last sentence which reads. "No member of this committee shall serve more than three terms."

REFERENCE COMMITTEE RECOMMENDATION—Item 1 of the Supplemental Report of the Committee on Constitution and Bylaws amends Chapter IX, Section 1, of the Bylaws by deleting said paragraph (G) therefrom. The effect of this amendment is to terminate the Committee on Emergency Medical Services as a Standing Committee of the Association. Lacking this designation, the Emergency Medical Services Committee thus becomes a Special Committee of the Association.

Mr. Speaker, your Reference Committee recommends adoption of Item 1.

Item 2 amends Chapter IX, Section 4, of the Bylaws by deleting reference to the number of terms a member may serve on the Professional Conduct and Medical Ethics Committee. At present, no one may serve more than three terms on this committee.

Mr. Speaker, your Reference Committee could find no good reason to limit service on this committee and, therefore, recommends adoption of the amendment.

HOUSE OF DELEGATES ACTION—Adopted the Supplemental Report of the Committee on Constitution and Bylaws.

AD HOC COMMITTEE ON ORGANIZATION AND FUNCTIONS

David A. Wells, M.D.

and

BIBB COUNTY COUNCILOR

(Recommendation 5)

Milton I. Johnson, Jr., M.D.

(For text of Recommendation 5 of the Bibb County Councilor's report, see reports under Reference Committee A. Recommendation 5 not approved.)

During the past year the Ad Hoc Committee on Organization and Functions has met three times in its continuing study of the structure and activities of the Medical Association of Georgia.

This committee was appointed pursuant to an action by the 1973 House of Delegates that called for a

sweeping, in-depth study of every major aspect of MAG from organization to activity.

The House was clear in what it wished to be undertaken. It mandated the appointment of a seven man committee and provided that four of these seven must not be associated with the MAG "establishment" in any respect. It was clear that the House wanted fresh points of view. It was equally clear that the House did not want to inhibit in any way the ability or likelihood of the committee from coming up with recommended changes that would be sound, significant and well-reasoned. In short, it provided for a committee that would not be overburdened with input from the hierarchy and yet closely enough related so that change merely for the sake of change would not be forthcoming.

The committee has undertaken a variety of study projects during the past year, and reports have been made to Council following each meeting of the committee. Those recommendations for change that required only the approval of Council have been instituted following presentation to and approval by Council. Among the projects engaged in to date are:

- A study and subsequent approval by Council for a new staff structure based on organizing and administering the activities of the Association along five distinct lines: administration, medical practice, education, research and development, and finance.
- A study of the committee structure. Although no conclusions have been reached as yet, there is strong committee agreement on the need to make several basic changes in committee structure. Under study is the concept of grouping committees of kindred interest under a single "umbrella" in a way calculated to improve efficiency, clarify the means by which committee recommendations may be brought to the attention of the Executive Committee and Council and, hopefully, to increase interest and activity and multiply committee productivity.

The purpose of this report, however, is not to dwell either on past accomplishments or on activities presently under active study. On the contrary, the committee wishes to make two specific recommendations, one of which goes to the heart of the MAG organization. These recommendations were not reached quickly or easily. They are, in fact, the product of extensive research, study, debate and compromise.

The members of the committee sincerely hope that these recommendations will be taken in the spirit in which they are given—solely that of improving the ability of the organization to deal with the increasingly complex problems confronting the medical profession.

RECOMMENDATIONS

1. Restructure the MAG Council to improve its operating efficiency and its ability to respond to the complex demands confronting the profession. To accomplish this, your committee recommends that Council be replaced by a Board of Directors and that the Board have the following characteristics:

A. Eliminate vice presidents, past presidents, vice councilors and all non-voting members of Council.

B. For election purposes (explained later), retain the current areas from which councilors are now elected.

C. The term "director" will replace "councilor" and directors will be elected by mail ballot conducted by the Headquarters Office. The presidents of the various county medical societies in the presently constituted councilor districts will act as nominating committees in their areas. Those districts that consist of the single county society must nominate a minimum of two candidates for each vacancy. (Such societies would be encouraged to develop a nominating procedure that offers a wide choice of the electorate.)

D. Directors will be elected for three year terms of office and will be eligible to succeed themselves two additional terms for a maximum tenure of nine years. Approximately one-third of the directors would be elected each year.

E. There shall be five officers: a president, president-elect, secretary, treasurer and speaker of the House of Delegates. These five officers would constitute the Executive Committee.

F. The Board of Directors shall have all of the powers currently held by Council. It shall be composed of the five officers plus one director from each of the present councilor districts plus additional directors as they are presently assigned to the larger county medical societies based on physician population to wit: MAA 3, Georgia Medical Society 1, Richmond 1, Bibb 1, Muscogee 1, DeKalb 1, Cobb 1, Floyd-Polk-Chattooga 1; plus the chairman of the AMA delegation as elected by the AMA delegates. This would constitute a 24 member Board of Directors as follows:

5	Officers
10	Directors from large county medical societies
8	Directors from present councilor districts
1	Chairman of AMA delegation
24	TOTAL

G. The president would serve as chairman of the Board of Directors.

H. The five officers and AMA delegates and alternates would be elected by the House of Delegates as is presently done: the secretary and treasurer elected for three year terms and eligible to succeed themselves for one additional term.

I. The Board of Directors would meet every second month for two full days and the Executive Committee would meet on call.

Discussion

It has become apparent to all that Council has grown too large to be an effective governing body; it has entirely too many ex-officio, non-voting members; and if it is to work to the advantage of the membership, it must be streamlined, reduced in size and mandated to meet more frequently in an atmosphere conducive to orderly and scholarly deliberation. At the present time, Council consists of 28 voting members and 45 non-voting members for a total of 73 members of Council. Rarely, if ever, does Council meet with less than 75 to 100 participants. Good order and scholarly deliberation in such an atmosphere is next to impossible and MAG effectiveness is suffering as a consequence.

The most obvious characteristic of this new Board of Directors is the absence of past presidents, vice presidents, vice councilors and other ex-officio members. On the new Board, all members would be voting members.

Your committee believes that greater membership input to the election of councilors (directors) would result from the use of a mail ballot. Generally speaking, district medical society meetings are poorly attended and the election of councilors and vice councilors is frequently the expression of a small minority of physicians in the district. In addition, the present system of electing councilors and vice councilors makes change an embarrassing and difficult process. We believe the use of a mail ballot would materially change and improve the present system.

Under this proposal, the president would serve as chairman of the Board. Thus the individual elected by the House as the leader of the Association would preside over the body that has month-to-month and week-to-week leadership responsibility.

The Council is not elected by the House of Delegates and, therefore, not answerable to the House. By installing the president, who is elected by the House, as the presiding officer of the Council (Board of Directors) a measure of responsibility and "answerability" to the House is achieved.

It is contemplated that the Board of Directors would meet for two full days every second month. This would provide for 12 full meeting days per year. At present, Council meets only four full days per year. Frequency of meetings would be changed through an amendment to the Bylaws.

RECOMMENDATION 2

In order to accomplish the foregoing, extensive amendments to the Constitution and Bylaws would be necessary. As you know, constitutional amendments are required to lay on the table a year before they can be voted on by the House. If it be the will of the House to make changes in the Council, then in the interests of time, the constitutional amendments required should begin to lay on the table at this meeting. This would permit the House to finalize its action next year at the 1976 House of Delegates meeting. The merit or lack of merit of these amendments is a matter for the House to decide in 1976 following review and language perfection by the Constitution and Bylaws Committee. It is the responsibility of this House of Delegates to acknowledge receipt of these amendments and thus officially mark the beginning of the year that they must lay over as a pre-condition of enactment.

The following constitutional changes would be necessary in order to accomplish the recommendations of the committee. In order to show what changes would be necessary, I have included each Article of the Constitution as it currently reads, followed by the language to accomplish the proposed changes.

ARTICLE VI.

Council

SECTION 1. COMPOSITION. Council is composed of the President, the President-Elect, the Immediate Past President, the two preceding Immediate Past Presidents, two Vice-Presidents, Secretary, Treasurer, Speaker of the House of Delegates and Councilors as provided for in the Bylaws. Delegates and alternate delegates to the AMA, Editor of the *Journal*, Past Presidents other than the three Immediate Past Presidents and the Executive Director shall be ex-officio members of Council without the right to vote. Vice-councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

SECTION 1. COMPOSITION. The Board of Directors is composed of the President, the President-Elect, Secretary, Treasurer, Speaker of the House of Delegates, Chairman of the AMA delegation and Directors as provided for in the Bylaws. In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into director districts.

SECTION 2. DUTIES. The Council is the Board of Trustees and the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws.

SECTION 2. DUTIES. The Board of Directors is the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates between sessions of that body. The Board of Directors has charge of all property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws.

ARTICLE VII.

Meetings

SECTION 1. ANNUAL SESSION. The Association shall hold an Annual Session at a time and place fixed by Council.

SECTION 1. ANNUAL SESSION. The Association shall hold an Annual Session at a time and place fixed by the Board of Directors.

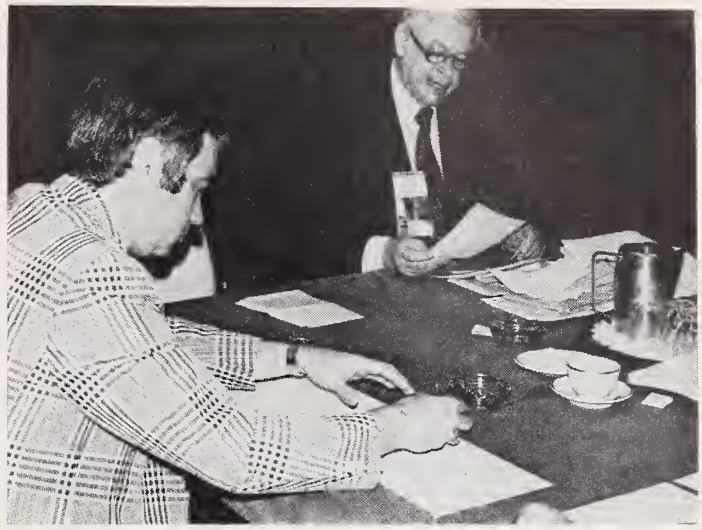
SECTION 2. HOUSE OF DELEGATES. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by Council.

SECTION 2. HOUSE OF DELEGATES. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by the Board of Directors.

SECTION 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, or upon written petition of one-third of the delegates of the House of Delegates, or upon written petition of one-fourth of the members of the Association.

SECTION 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Board of Directors or upon written petition of one-third of the delegates of the House of Delegates, or upon written petition of one-fourth of the members of the Association.





Rodney Browne of Macon collects ballots at the House of Delegates, then with Thomas J. Anderson, Jr., fellow member of the Tellers Committee, begins the careful process of counting votes.

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of State into councilor districts and for the organization of all component county societies in the districts into councilor district medical societies.

ARTICLE VIII

(Delete in its entirety)

All subsequent articles would then be renumbered.

ARTICLE IX.

Officers

SECTION 1. DESIGNATION. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Councilors and Vice-Councilors as provided for in the Bylaws.

ARTICLE VIII

Officers

SECTION 1. DESIGNATION. The officers of the Association shall be a President, President-Elect, Secretary, Treasurer, and Speaker of the House of Delegates as provided for in the Bylaws.

SECTION 2. ELECTION AND ELIGIBILITY. The officers of the Association, with the exception of the councilors and vice-councilors shall be elected during the Annual Session as provided for in the Bylaws. Councilors and vice-councilors shall be elected as provided for in the Bylaws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

SECTION 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected during the Annual Session as provided for in the Bylaws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

SECTION 3. TERM OF OFFICE OF PRESIDENT-ELECT. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session.

SECTION 3. TERM OF OFFICE OF PRESIDENT-ELECT. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. If the President dies, resigns, is removed from office or is otherwise unable to serve, the President-Elect shall immediately become President and shall serve for the remainder of the unexpired term.

SECTION 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, the Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates and the Councilors and Vice-Councilors who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

SECTION 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, the Treasurer and Speaker of the House of Delegates, who shall serve for three years. (A Vice Speaker of the House of Delegates shall be elected for a three year term and shall serve concurrently with the Speaker.) One-third of the Directors shall be elected annually. All officers shall serve until their successors are elected and installed.

SECTION 5. SUCCESSOR TO THE PRESIDENT. If the President dies, resigns, or is removed from office, the First Vice-President shall immediately become President and shall serve for the remainder of the un-

expired term. If the First Vice-President is unable to serve, then the Second Vice-President shall fill the office.

In event a catastrophic occurrence shall exhaust the aforementioned line of succession to the Presidency, the Speaker of the House of Delegates or the Vice Speaker, if the Speaker is unable to act, shall be authorized to convene an emergency meeting of the House of Delegates for the purpose of naming an Acting President to serve until the next Annual Session. The Acting President, so named, shall have all the powers and duties of the President during the term for which he is elected to serve. Should the Speaker and the Vice Speaker both be unable to act, then five Councilors or any 10 delegates shall be authorized to convene the House of Delegates in emergency meeting. Such other acting officers as necessary shall also be named at this time to serve until the next Annual Session.

SECTION 5. SUCCESSION TO THE PRESIDENCY. In event a catastrophic occurrence shall exhaust the aforementioned line of succession to the Presidency, the Speaker of the House of Delegates or the Vice Speaker, if the Speaker is unable to act, shall be authorized to convene an emergency meeting of the House of Delegates for the purpose of naming an Acting President to serve until the next Annual Session. The Acting President, so named, shall have all the powers and duties of the President during the term for which he is elected to serve. Should the Speaker and the Vice Speaker both be unable to act, then five Directors or any 10 delegates shall be authorized to convene the House of Delegates in emergency meeting. Such other acting officers as necessary shall also be named at this time to serve until the next Annual Session.

ARTICLE X.

Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society. The amount of assessment shall be set by the House of Delegates upon recommendation of Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by Council. The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

ARTICLE IX

Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society. The amount of assessment shall be set by the House of Delegates upon recommendation of the Board of Directors. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the Board of Directors. The Board of Directors shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

ARTICLE XI.

Official Publication

The official publication of the Association shall be the *Journal of the Medical Association of Georgia,* in which shall be published all official Association notices, abstracts of transactions of the House of Delegates, and general meetings of the Association, the annual budget, complete financial reports as directed by Council, and abstracts of meetings of Council.

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The official publication of the Association shall be the Journal of the Medical Association of Georgia, *in which shall be published all official Association notices, abstracts of transactions of the House of Delegates, and general meetings of the Association, the annual budget, complete financial reports as directed by the Board of Directors, and abstracts of meetings of the Board of Directors.*

ARTICLE XI

Seal

ARTICLE XII

Amendments

RECOMMENDATION 3

Reapportion the House of Delegates so that the current approximate size of the House may be maintained.

Discussion

Your committee feels that the House of Delegates should be stabilized at approximately 200 delegates and a corresponding number of alternate delegates. The present size of the House is based on one delegate for each 25 members or fraction thereof. Currently there are 192 delegates—an increase from 186 since the last meeting. Therefore, your committee feels that the House should agree on a higher number; for example, one delegate for each 30 or 35 members (or fraction thereof) as the new basis for determining the size of the House.

The House should instruct the Council to direct the Constitution and Bylaws Committee to draw up an amendment to Chapter III, Section 2, of the Bylaws to accomplish the desired change.

REFERENCE COMMITTEE RECOMMENDATION —As indicated earlier the Reference Committee considered the report of the Committee on Organization and Functions and the Report of the Bibb County Councilor together as they both speak to the issue of reorganization of Council.

The Report of the Ad Hoc Committee is a detailed "blue print" for the complete reorganization of Council whereas the Bibb County Councilor Report concerns itself only with the issue of keeping vice councilors as members of Council.

In any reorganization plan, the potential for misunderstanding is present. The Ad Hoc Committee recognizes this and your Reference Committee would like to quote from their report in the hope of minimizing misunderstanding. The report states "The members of the Committee sincerely hope that these recommendations will be taken in the spirit in which

they are given—solely that of improving the ability of the organization to deal with the increasingly complex problems confronting the medical profession."

The Ad Hoc Committee makes three recommendations. They are:

RECOMMENDATION 1:

Restructure the MAG Council to improve its operating efficiency and ability to respond to complex demands confronting the profession. This is, of course, the heart of the report of the Ad Hoc Committee. To accomplish this, the Organization and Functions Committee outlined nine recommendations all of which relate to a name change from "Council" to "Board of Directors," composition of the Board, the method of election and the frequency with which the Board should meet. After weighing all of the testimony heard, your Reference Committee believes that the House should approve Recommendation 1 as amended below.

The Board of Directors shall have the following characteristics:

A. (1) Eliminate vice presidents from the Board (by unanimous Reference Committee vote).

(2) Eliminate all past presidents except the immediate past president (by unanimous Reference Committee vote).

(3) Eliminate vice councilors (by 4 to 1 vote of Reference Committee).

(4) Eliminate all non-voting members of Council (by unanimous Reference Committee vote).

Mr. Speaker, your Reference Committee recommends approval of Part A.

B. Part B of Recommendation 1 calls for retention of present election districts.

Mr. Speaker, your Reference Committee recommends approval of Part B.

C. Part C calls for election of Directors by a mail ballot. Your Committee was impressed by the weight of the testimony that such a procedure would greatly improve and increase participation in the election process over that currently experienced by most district medical societies. This method of election was favored by the Reference Committee.

Mr. Speaker, your Reference Committee recommends approval of Part C.

D. Part D follows the current provisions in the Bylaws (Chapter V, Section 1) stipulating that terms of office shall be for three years. It makes one important change in that it provides for maximum tenure of nine years for Directors, whereas there is presently no limit on the number of years a member may stay on Council.

Mr. Speaker, your Reference Committee recommends approval of Part D of Recommendation 1.

E. Part E provides that there shall be five officers who will constitute the Executive Committee. They shall be a president, president-elect, secretary, treasurer and speaker of the House of Delegates. Your Reference Committee recommends approval of Part E.

F. Part F transfers all the powers held by Council to the new Board of Directors and provides for additional Directors on the Board in the same fashion as additional Councilors are given to the larger medical societies at the present time. Your Reference Committee recommends two changes from the recommendation made by the Ad Hoc Committee. These are:

- increase the total size of the Board from 24 to 25 by inclusion of the immediate past president as a voting member of the Board;
- and by providing that the chairman of the AMA Delegation be selected by the Board rather than by the AMA delegates and alternate delegates. The current delegation chairman felt that this would be an improvement and your committee agrees with the wisdom of his suggestion.

Mr. Speaker, your Reference Committee recommends approval of Part F.

G. Part G provides that the Board shall elect its chairman from among the members of the Board. This differs from the position of the Ad Hoc Committee that recommended that the president also serve as chairman of the Board. Your Reference Committee felt that it was an unnatural deviation from corporate board structure to deny (the Board) the prerogative to elect its own chairman.

Mr. Speaker, your Committee recommends approval of Part G as changed above.

H. Part H provides that the officers shall be elected by the House as is presently done and that the secretary and treasurer shall serve three year terms with a maximum tenure of six years each (as is presently the case). Your Reference Committee recommends approval of Part H.

I. Part I calls for the new Board to meet two days every second month. Your Reference Committee is aware of the need for more frequent meetings as amply evidenced by the ever-increasing length of current Council meetings. Your Reference Committee recommends approval of Part I.

RECOMMENDATION 2:

As everyone understands there is no way any of the preceding recommendations can be carried out until the Constitution has been properly amended to authorize implementation. In addition, everyone understands that constitutional amendments must lay of the table for one year before they can be voted on either affirmatively or negatively. Accordingly, your Reference Committee recommends the acceptance of the constitutional amendments offered by the Ad Hoc Committee on Organization and Functions with one change in the proposed Article VI, Section 1 to include the immediate past president as a member of the Board of Directors. In summary, these constitutional amendments would provide:

Article VI

Section 1—changes the name of Council to Board of Directors and specifies the composition of the Board.

Section 2—deletes the word "Council" and substitues the words "Board of Directors."

Article VII

Section 1—deletes the word "Council" and substi-

tutes the words "Board of Directors."
Section 2—deletes the word "Council" and substitutes the words "Board of Directors."
Section 3—deletes the word "Council" and substitutes the words "Board of Directors."

Article VIII—deletes said Article in its entirety thus terminating any reference to the organization of district medical societies. All subsequent articles are then renumbered.

Article VIII (renumbered)
Section 1—renames the officers of the Association as follows: president, president-elect, secretary, treasurer and speaker of the House of Delegates.
Section 2—provides for the election of the officers at the Annual Session.
Section 3—provides for the president-elect to fill the unexpired term of office of the president if the president is unable to complete his term.
Section 4—deletes the words "councilor" and "vice-councilor" and substitutes the word "directors."
Section 5—deletes the word "councilors" and substitutes the word "director." The line of succession to the presidency described in the first paragraph of Section 5 has been deleted and the succession clause transferred to Section 3 of Article VIII.

Article IX—deletes the word "Council" and substitutes the words "Board of Directors."

Article X—deletes the word "Council" and substitutes the words "Board of Directors."

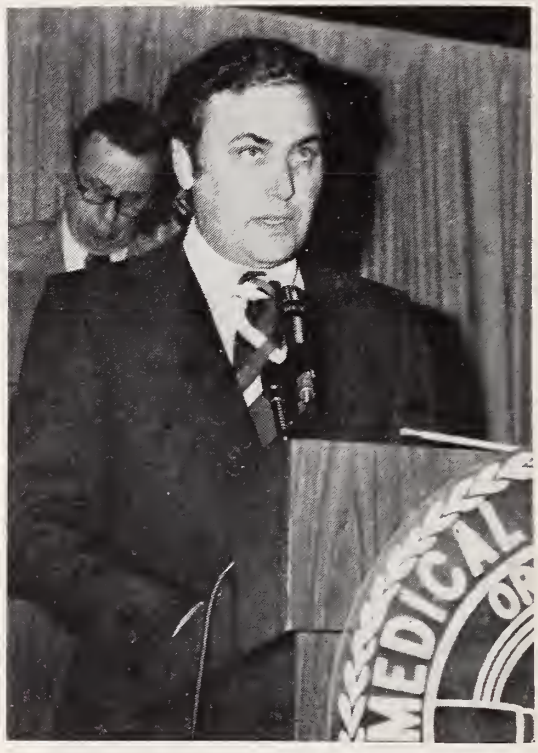
Mr. Speaker, your Reference Committee is fully cognizant of the effect of these numerous changes being recommended. Your Committee feels that it is time for this issue to cease being in the jurisdiction of small committee groups and that it should be brought out into the open to become items for proper debate and consideration by every county medical society in the state. In view of the fact that a year's moratorium exists by reason of the requirements necessary to amend the Constitution and Bylaws and with the view that it must come back to this House in 1976, and with the hope that this issue will be considered by all county societies throughout the state, your Reference Committee moves the adoption of Recommendation 1 and 2 of the Ad Hoc Committee on Organization and Functions as amended by the Reference Committee.

RECOMMENDATION 3:

This calls for reapportionment of the House of Delegates to stabilize the size of the House at its current approximate size. Your Reference Committee heard no testimony that improved upon the equitable method of one delegate (and one alternate) per 25 members or fraction thereof as the basis for determining the size of this House of Delegates. In the absence of any recommendation that improves the situation, your Reference Committee recommends that the House disapprove Recommendation 3.

HOUSE OF DELEGATES ACTION—Delegate J. Rhodes Haverty moved that the report of the Ad Hoc Committee on Organization and Functions be referred back to the Ad Hoc Committee on Organization and Functions for additional study. This motion was duly seconded and adopted by the House of Delegates.

Chairman Hammett expressed his appreciation to the members of the Reference Committee for their time and effort and also expressed his appreciation for the assistance provided to the Reference Committee by the MAG officers and others.



Reference Committee F

REPORT OF REFERENCE COMMITTEE F

H. Duane Blair, M.D., Chairman

Chairman Blair reported to the House of Delegates that the reports and resolutions referred to Reference Committee F, which met at 1:45 p.m. in the Far East Room, Fairmont Colony Square Hotel, Atlanta, Georgia, on April 18, 1975, had been considered by the entire committee. Members of the committee present included: H. Duane Blair, M.D., Decatur, Chairman; Stuart Prather, M.D., Augusta, Vice Chairman; James H. Manning, M.D., Marietta; John S. Atwater, M.D., Atlanta; James H. Sullivan, M.D., Columbus; and Robert D. Waller, M.D., Albany.

SECRETARY

(Recommendation 1)

Earnest C. Atkins, M.D.

(Recommendation 1 of the report of the Secretary was considered by Reference Committee F. For a full text of the Secretary's report, see reports listed under Reference Committee A.)

RECOMMENDATION

1. No increase in dues this year but to operate MAG efficiently and economically, so when a dues in-

crease is imperative, we can show the members that we have cut the expenses to the bone. This will also help retain any present members as in our new membership drive.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed with interest the suggestion that MAG be operated efficiently and economically, and that there would be no dues increase this year.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 1.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 of the report of the Secretary.

CHAIRMAN OF COUNCIL

Fleming L. Jolley, M.D.

(Recommendation 3 of the report of the Chairman of Council was considered by Reference Committee F. For full text of the report, see reports under Reference Committee A.)

3. Accept the Research and Development Component of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has carefully reviewed Recommendation 3 and agrees that the Research and Development component of MAG be accepted.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 3.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 3 of the report of the Chairman of Council.

COMMITTEE ON ACCESS TO HEALTH CARE

M. C. Adair, M.D.

(Recommendation 1 of the Committee on Access to Health Care was considered by Reference Committee F. For full text of the report, see reports under Reference Committee A.)

RECOMMENDATIONS

1. That the Manpower Study proposed by the Medical Association of Georgia be implemented in July 1975 lasting two months and that a budget of $5,000 (a copy of which is appended) be applied to this Manpower Study utilizing the services of Mr. John Harrington.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has debated the problems of the Health Manpower Study and approves Recommendation 1. While serious debate arose concerning any useful results from this study to date, your committee feels that funds should be approved so that data already accumulated may be processed and utilized.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 1.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 of the report of the Committee on Access to Health Care.

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. George I. Harrison, President

(Recommendations 3, 4 and 5 of the report of the Woman's Auxiliary to the Medical Association of Georgia were considered by Reference Committee F. For full text of the report, see reports under Reference Committee D.)

3. MAG shall collect Auxiliary membership dues at such time as MAG adopts a centralized, computerized billing system with all component societies participating.

4. The Auxiliary be permitted to arrange for the publication of our directory with MAG monetary support.

5. The Auxiliary be permitted to disburse the funds allocated by MAG for Auxiliary convention expenses.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has reviewed the report of the Woman's Auxiliary and compliments its fine activities. Your Committee agrees that MAG should refrain from collecting Auxiliary dues until such time as billing can be centralized as requested in Recommendation 3.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 3.

After considering Recommendation 4 regarding directory publication, your Reference Committee agrees that the Auxiliary be permitted to publish their directory with financial assistance from MAG. This should result in a saving to the Medical Association of Georgia.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 4.

With regard to Recommendation 5, your Reference Committee feels that the Woman's Auxiliary should disburse funds allocated by MAG for their convention expenses.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 5.

HOUSE OF DELEGATES ACTION—Adopted Recommendations 3, 4 and 5 of the report of the Woman's Auxiliary to the Medical Association of Georgia.

SUPPLEMENTAL REPORT A OF COUNCIL

Fleming J. Jolley, M.D.

Professional Liability Insurance coverage is becoming increasingly difficult to obtain. Georgia Physicians are limited to $1,000,000 excess coverage instead of the $5,000,000 available in 1974. Forty states out of the 50 are in serious difficulty securing basic $100/$300 coverage.

MAG Council, after hearing a report from the Insurance and Economics Committee, requests an increase in the budget for 1975-76 for actuarial services to $10,000 for use, if necessary.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee realizes the crisis in

the Professional Liability Insurance field and approves the additional budget request recommended by Council. Your Reference Committee recommends that the Executive Director of the Medical Association of Georgia be kept informed of the need for significant monies prior to their actual expenditure for legal or actuarial services.

Mr. Speaker, your Reference Committee recommends approval of Supplemental Report A.

HOUSE OF DELEGATES ACTION—Adopted Supplemental Report A of the Council.

RESOLUTION 13-75
REPEAL OF THE PSRO LAW

Jack F. Menendez, M.D., Delegate,
Bibb County Medical Society

WHEREAS, the Medical Association of Georgia's House of Delegates has wisely opposed this law; and,

WHEREAS, the Association of American Physicians and Surgeons is at present engaged in a costly suit to declare Public Law 92-603 unconstitutional,

BE IT RESOLVED THAT the Medical Association of Georgia show their continued resolve for repeal of this legislation by contributing $1,000.00 to the Association of American Physicians and Surgeons for payment of legal fees in their attempt to repeal the PSRO law.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee has carefully considered this resolution which concerns a $1,000.00 donation to the American Association of Physicians and Surgeons. Your Committee feels this action would set a precedent of donation of MAG Funds and would be a duplication of monies already expended.

Mr. Speaker, your Reference Committee recommends disapproval of Resolution 13.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 13-75.

SUPPLEMENTAL REPORT OF COUNCIL

Fleming L. Jolley, M.D., Chairman

Summary-Comparison of Budgeted and Actual Operations—Medical Association of Georgia

Period June 1, 1974 to March 31, 1975

	Budget 6/1/74 5/31/75	*Actual 6/1/74 3/31/75*	*(Over) Under Budget*	*Proposed Budget 1975-1976*
INCOME				
1. MAG Dues	$350,000.00	$340,430.00	$ 9,570.00	$360,000.00
2. Interest and AMA	26,000.00	34,929.78	(8,929.78)	26,000.00
3. Parking	6,000.00	2,935.00	3,065.00	4,800.00
4. *Journal*	42,000.00	35,461.15	6,538.85	42,000.00
5. Contingent—Transfer from Operating Capital	89,717.00		89,717.00	
6. Contingent Loss				145,671.00
TOTAL INCOME	$513,717.00	$413,755.93	$ 99,961.07	$578,471.00
EXPENSE				
1. Fixed Allotments	$123,360.00	$ 82,143.05	$ 41,216.95	$119,900.00
2. Association Office	219,333.00	157,472.11	61,860.89	271,540.00
3. Association Committees	58,455.00	29,142.56	29,312.44	55,246.00
4. Related MAG Activities	19,075.00	14,278.89	4,796.11	21,375.00
5. Executive Committee Discretionary Fund	10,000.00	600.31	9,399.69	10,000.00
6. Contingent—Fund for use of Council from Operating Capital	10,000.00	12,494.31	(2,494.31)	10,000.00
7. *Journal*	54,894.00	45,622.69	9,271.31	55,310.00
8. Research and Development				16,500.00
9. Depreciation				
Building	15,000.00	12,500.00	2,500.00	15,000.00
Equipment	3,600.00	3,000.00	600.00	3,600.00
TOTAL EXPENSE	$513,717.00	$357,253.92	$156,463.08	$578,471.00

CASH AVAILABLE

	3/31/75	*3/31/74*
C & S Checking Account	$ 31,269.26	24,984.31
C & S Certificates	452,134.16	505,532.74
TOTAL	$483,403.42	$530,517.05

	Budget 6/1/74 5/31/75	*Actual 6/1/74 3/31/75*	*(Over) Under Budget*	*Proposed Budget 1975-1976*
Restricted Funds included in Cash Available				
Regular	$ 30,000.00			
Building Depreciation	40,213.00			
Equipment Depreciation	2,400.00			
MAG Foundation	3,200.00			
	$ 75,813.00			
1. FIXED ALLOTMENTS				
Interest on Mortgage	$ 38,295.00	$ 30,412.50	$ 7,882.50	$ 37,100.00
Retainers—Legal, Insurance, Actuary, Other	21,500.00	17,844.63	3,655.37	27,000.00
President's Honorarium	2,400.00	1,654.20	745.80	2,400.00
Annual Audit	2,900.00	2,900.00		3,050.00
Taxes	22,000.00	10,170.67	11,829.33	12,100.00
Retirement Contribution	11,915.00	1,484.64	10,430.36	13,400.00
Retirement Trust Fee	250.00		250.00	300.00
Woman's Auxiliary	14,900.00	10,648.21	4,251.79	14,450.00
MAG Foundation	3,200.00		3,200.00	3,600.00
MAG Roster	6,000.00	7,028.20	(1,028.20)	6,500.00
TOTAL FIXED ALLOTMENTS	$123,360.00	$ 82,143.05	$ 41,216.95	$119,900.00
2. ASSOCIATION OFFICE				
Salaries	$187,940.00	$166,324.02	$ 21,615.98	$221,415.00
Insurance and Bonds	15,318.00	10,107.28	5,210.72	15,340.00
Payroll Tax	10,075.00	7,992.67	2,082.33	11,300.00
Travel—President	2,500.00	1,473.83	1,026.17	2,900.00
Travel—Past President	1,700.00	914.41	785.59	1,800.00
Travel—President Elect	1,200.00	788.67	411.33	1,800.00
Travel—Office	21,000.00	10,394.68	10,605.32	25,435.00
Travel—Exec. Comm.	2,200.00	2,167.35	32.65	3,000.00
Maintenance				
Building	3,600.00	2,601.52	998.48	3,600.00
Equipment	1,200.00	1,187.20	12.80	2,400.00
Telephone	7,200.00	6,513.74	686.26	8,460.00
WATS Line	3,600.00	2,603.04	996.96	3,600.00
Postage	8,400.00	6,952.82	1,447.18	8,400.00
Office Supplies	6,000.00	4,445.38	1,554.62	5,940.00
Janitorial, Supplies and Security	9,200.00	8,520.29	679.71	8,800.00
Meetings	1,800.00	1,261.16	538.84	1,800.00
Dues and Subscriptions	1,000.00	800.82	199.18	1,650.00
Utilities	13,200.00	11,877.60	1,322.40	14,200.00
Sundry	200.00		200.00	200.00
Equipment	12,000.00	2,082.61	9,917.39	4,500.00
	$309,333.00	$249,009.09	$ 60,323.91	$346,540.00
Less Reimbursable Expense	90,000.00	91,536.98	(1,536.98)	75,000.00
NET ASSOCIATION OFFICE	$219,333.00	$157,472.11	$ 61,860.89	$271,540.00
3. ASSOCIATION COMMITTEES				
Standing Committees:				
Annual Session				
Business	$ 6,050.00	$ 352.51	$ 5,697.49	$ 7,950.00
Scientific				9,701.00
Special Committees:				
Emergency Medical Service	300.00	75.00	225.00	
Awards	400.00	185.80	214.20	750.00
Communications	26,875.00	13,147.55	13,727.45	15,390.00
Education	2,400.00	732.74	1,667.26	2,435.00
Insurance and Economics	675.00		675.00	150.00
Legislation				
State	7,055.00	6,741.19	313.81	6,430.00
National	3,600.00	1,943.35	1,656.65	2,800.00
Peer Review	125.00		125.00	325.00
Medical Aspect of Sports				1,150.00
Mental Health	400.00		400.00	400.00

	Budget 6/1/74 5/31/75	Actual 6/1/74 3/31/75	(Over) Under Budget	Proposed Budget 1975-1976
Quackery	2,200.00	382.07	1,817.93	350.00
Occupational Health	100.00	100.00		100.00
Access to Health Care, Rural and Urban				1,965.00
Rural Health	1,125.00	842.16	282.84	
PSRO	2,650.00	1,362.62	1,287.38	
School Child Health	800.00	253.27	546.73	350.00
Public Health	700.00	24.30	675.70	2,000.00
Contribution to GaMPAC	3,000.00	3,000.00		3,000.00
TOTAL ASSOCIATION COMMITTEES	$ 58,455.00	$ 29,142.56	$29,312.44	$ 55,246.00
4. RELATED MAG ACTIVITIES				
Delegates and Secretary Travel to AMA Meetings	$ 7,300.00	$ 6,824.08	$ 475.92	$ 7,975.00
Alternate Delegates and Treasurer Travel to AMA Meetings	7,300.00	4,449.60	2,850.40	8,150.00
AMA Leadership Conference (2 Officers)				650.00
AMA Delegates Group Costs:				
Breakfasts	1,200.00	803.72	396.28	1,100.00
MAG Suite and Hospitality	1,000.00	1,130.33	(130.33)	1,300.00
Southeastern Hospitality	1,000.00	633.96	366.04	900.00
Interprofessional Council	125.00		125.00	125.00
SAMA	500.00	250.00	250.00	500.00
SAMA—MAG Annual Session	450.00		450.00	450.00
State Medical Education Luncheon	200.00	187.20	12.80	225.00
TOTAL RELATED ACTIVITIES	$ 19,075.00	$ 14,278.89	$ 4,796.11	$ 21,375.00
5. EXECUTIVE COMMITTEE				
Discretionary Fund	$ 5,000.00	$ 600.31	$ 4,399.69	$ 5,000.00
Committee Contingent Fund	5,000.00		5,000.00	5,000.00
TOTAL	$ 10,000.00	$ 600.31	$ 9,399.69	$ 10,000.00
6. CONTINGENT FUND				
(For Council to Spend where Items not Budgeted)	$ 10,000.00			$ 10,000.00
Heard Campaign*		$ 1,612.82		
Taxes—Appraisal		1,750.00		
Tuition—Moffett		64.65		
Office Renovation		655.00		
Moving Expense		850.00		
Additional Rosters		1,650.00		
Ga. Council for Family Practice Education		700.00		
Repeal PSRO†				
Communication		2,474.50		
Postage		516.70		
Public Relation		1,995.31		
Travel (Crane)		225.33		
TOTAL CONTINGENT	$ 10,000.00	$ 12,494.31	$ (2,494.31)	$ 10,000.00
7. JOURNAL				
Printing	$ 35,803.00	$ 30,587.92	$ 5,215.08	$ 36,000.00
Salaries	12,504.00	10,420.00	2,084.00	13,100.00
Insurance	994.00	742.51	251.49	900.00
Payroll Tax	883.00	668.25	214.75	875.00
Engraving and Cuts	2,325.00	1,540.48	784.52	2,025.00
Postage and Copyright	1,860.00	1,466.84	393.16	1,860.00
Clipping Service	175.00	181.92	(6.92)	200.00
Addressograph and Supplies	300.00	11.38	288.62	300.00
Sundry	50.00	3.39	46.61	50.00
TOTAL JOURNAL	$ 54,894.00	$ 45,622.69	$ 9,271.21	$ 55,310.00
8. RESEARCH AND DEVELOPMENT				
TOTAL RESEARCH AND DEVELOPMENT				$ 16,500.00

* Total Expense Dr. Heard's Campaign 3/31/75—$3,500.00.
† Total Expense Repeal PSRO 3/31/75—$36,092.06.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has reviewed each item in the budget for 1975-1976 and recommends approval.

HOUSE OF DELEGATES ACTION—F. G. Eldridge, M.D., Chairman of the Committee on Finance was asked to explain two changes in the budget made by the Reference Committee. The changes explained by Dr. Eldridge which are indicated in the summary comparison printed herewith consisted of a $6,000 increase in insurance actuarial costs and an $850 reduction in appropriations to the MAG Auxiliary. The House adopted the Supplemental Report of Council (budget) as amended by the Reference Committee.

SECOND VICE PRESIDENT

W. Dan Jordan, M.D.

For the past year, functioning as 2nd Vice President, I have attended all Council meetings and all (with one exception) Executive Committee meetings. During the course of these somewhat laborious deliberations, it has become increasingly apparent that much of our discussion and time occupied centers around governmental relationships. In each of these meetings some time has been devoted to the possibility, probability, likelihood, and occasionally the desirability of obtaining some form of government grant. Relatively little time has been devoted to the reports of how this has truly benefitted the members of the Medical Association of Georgia and/or their patients. With these thoughts in mind, I would make the following

RECOMMENDATIONS

1. That the House of Delegates instruct the Research and Development branch of Medical Association of Georgia to prepare a report of all grants and contracts applied for and/or received (in the name of the Medical Association of Georgia or any of its subsidiary groups) since 1 January 1969, including their assessment of each transaction as to:

a. Efficiency of administration
b. Effectiveness of purpose
c. Benefits to MAG members
d. Benefits to the public

2. That the House of Delegates of Medical Association of Georgia call for a suspension of the application for monies from any governmental source (not to include the relationship between Georgia Medical Care Foundation and the Department of Human Resources concerning the administration of the Medicaid program), pending the evaluation of the above report by the House of Delegates in 1976.

3. That the above report be completed prior to 1 January, 1976, and distributed to the delegates prior to the annual session in 1976.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has carefully considered and debated all phases of this report. Your Reference Committee agrees that the Research and Development Component should prepare a report of all grants applied for and received since 1969 for assessment and evaluation.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 1.

With regard to Recommendation 2, stating that all applications for monies from any governmental source should be suspended until such report is aproved by the House of Delegates, your Reference Committee felt that this would not be in the best interest of MAG.

Mr. Speaker, your Reference Committee recommends disapproval of Recommendation 2.

As for Recommendation 3, your Reference Committee agrees that the report of all grants and contracts should be completed prior to 1 January 1976, and distributed to the Delegates in time for study prior to the 1976 Annual Session.

Mr. Speaker, Your Reference Committee recommends approval of Recommendation 3.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 of the Second Vice President's report, and disapproved Recommendation 2. Adopted Recommendation 3 of the Second Vice President's report.

RESOLUTION 11-75 EVALUATION OF MAG PRIORITIES

BIBB COUNTY MEDICAL SOCIETY

WHEREAS, the purposes of the Medical Association of Georgia, as stated in the Constitution and Bylaws are "to promote the science and art of medicine and the betterment of public health"; and,

WHEREAS, during recent years the MAG has become so deeply involved in dealing with governmental affairs that our lofty ideals seem to have been relegated to a role of secondary importance; and,

WHEREAS, while we are fully cognizant of the need to have a strong organization to represent us in dealing with the federal and state governments, third party carriers and others, we are concerned that the MAG may be losing support at the "grass roots" level; and,

WHEREAS, the Annual Report of the Secretary includes a clear implication that a dues increase will be necessary in the near future; and,

WHEREAS, although the inflationary era in which we live may necessitate such an action, we wish to insure that the MAG does not incur financial obligations for programs in which the rank and file members can see no benefit; and

WHEREAS, the AMA may never fully recover from the adverse reaction of its members to the recently imposed assessment, much of the discontent resulting from extravagant expenditures, therefore

BE IT RESOLVED, That the MAG should profit from the aforementioned AMA experience; and be it further

RESOLVED, That operating expenses, including those associated with Annual Sessions, Council Meetings and other necessary convocations, be carefully scrutinized so that no criticism of extravagant expenditures for such purposes can be justified, and be it further

RESOLVED, That neither the MAG nor its subsidiaries should enter into any contractual agreement with governmental agencies or other third parties which obligate the expenditure of MAG funds for the continuation of projects initially funded by said governmental

agencies or other third parties, and be it further

RESOLVED, That neither the MAG nor its subsidiaries should undertake any new programs which are not relevant to the purposes upon which our organization was founded unless such programs are approved by the House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION —After study, your Reference Committee does not agree with this resolution, but recommends that the officers and staff of the Medical Association of Georgia have an ongoing communication with the component county medical societies regarding the fiscal responsibilities and priorities of the Medical Association of Georgia.

Mr. Speaker, your Reference Committee recommends disapproval of this resolution.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 11-75.

Chairman Blair moved the adoption of the report of the Reference Committee as a whole. This was approved by the House of Delegates.

Chairman Blair expressed his appreciation to the members of the Reference Committee for their time and effort and thanked the MAG officers and others for assistance rendered to the committee.

Election Results

Speaker Buchanan, having received the results of the election from the Tellers Committee, announced the election results as follows:

President-Elect—Fleming L. Jolley; Second Vice President—James H. Sullivan; Secretary—Earnest C. Atkins; Treasurer—Carson B. Burgstiner; AMA Delegate (J. W. Chambers seat)—C. E. Bohler; AMA Delegate (John S. Atwater seat)—F. William Dowda; AMA Alternate Delegate (F. G. Eldridge seat)—F. G. Eldridge; AMA Alternate Delegate (Luther M. Vinton seat)—Charles D. Hollis, Jr.; AMA Alternate Delegate (C. E. Bohler seat)—H. Hilt Hammett, Jr.; Ninth District Councilor—Harvey M. Newman; Ninth District Vice Councilor—L. Austin Flint; Tenth District Councilor—Edwin W. Allen, Jr.; Tenth District Vice Councilor—M. A. Hubert.



In a traditional exchange symbolizing a change in leadership, outgoing President J. Rhodes Haverty passes the gavel to incoming President David A. Wells of Dalton.

The Speaker called for unfinished business and there was none. He asked for new business and none was reported.

Speaker Buchanan thanked all members of the Reference Committees for their diligent work and thanked all members of the House of Delegates for their close attention to the work of the House. He called for a motion to adjourn the Second Session of the MAG House of Delegates and on motion made and seconded, he declared the Final Session of the House of Delegates adjourned (2:35 p.m.) and turned the meeting back to President J. Rhodes Haverty for the closing General Session and installation of officers.

MAG Final General Session

1975 Annual Session Business Meeting

Sunday, April 20, 1975

PRESIDENT HAVERTY CONVENED the Final Session of the 1975 Annual Session Business Meeting and expressed his appreciation to Drs. Buchanan and Galloway for their efficient handling of the business of the House of Delegates.

Installation of Officers

Dr. Haverty asked the incoming President, the other new officers, the AMA delegates and alternates, councilors and vice councilors to assemble in front of the Speaker's platform for the purpose of taking the oath of office and the installation as follows:

President
David A. Wells, Dalton (1976)
President-Elect
Fleming L. Jolley, Atlanta (1976)
First Vice President
W. Daniel Jordan, Atlanta (1976)
Second Vice President
James H. Sullivan, Columbus (1976)
Ninth District Councilor
Harvey M. Newman, Gainesville (1978)
Ninth District Vice Councilor
L. Austin Flint, Canton (1978)
Tenth District Councilor
Edwin W. Allen, Jr., Milledgeville (1978)
Tenth District Vice Councilor
M. A. Hubert, Athens (1978)
Bibb County Councilor
Milton I. Johnson, Macon (1978)
Bibb County Vice Councilor
Beverly B. Sanders, Macon (1978)
Cobb County Councilor
Charles R. Underwood, Marietta (1978)
Cobb County Vice Councilor
Frank W. McKinnon, Marietta (1978)
DeKalb County Councilor
Luther M. Vinton, Jr., Avondale Estates (1978)
DeKalb County Vice Councilor
Stanley P. Aldridge, Decatur (1978)
Floyd-Polk-Chattooga Councilor
John I. Dickinson, Rome (1978)
Floyd-Polk-Chattooga Vice Councilor
Lee H. Battle, Rome (1978)
Medical Association of Atlanta Councilor
Fleming L. Jolley, Atlanta (1978)
Medical Association of Atlanta Vice Councilor
T. J. Anderson, Atlanta (1978)
Richmond County Medical Society Councilor
Ronald F. Galloway, Augusta (1978)
Richmond County Medical Society Vice Councilor
Henry D. Scoggins, Augusta (1978)
Secretary
Earnest C. Atkins, Decatur (1978)
Treasurer
Carson B. Burgstiner, Savannah (1978)
AMA Delegate
C. E. Bohler, Brooklet (1977)
F. William Dowda, Atlanta (1977)
AMA Alternate Delegates
F. G. Eldridge, Valdosta (1977)
Charles D. Hollis, Jr., Albany (1977)
H. Hilt Hammett, Jr., LaGrange (1976)
William W. Moore, Atlanta (1976)

President Haverty administered the oath of office to the assembled new officers of MAG and declared each of the officers duly installed. Dr. Haverty turned the gavel of leadership over to the incoming President, David A. Wells, who expressed his appreciation for the honor of being selected President for 1975-76 year. Dr. Wells then presented to Dr. Haverty the President's Key and a bound volume of the issues of the *Journal of the Medical Association of Georgia* published during Dr. Haverty's term of office.

Dr. Wells announced the date and site of the MAG Annual Session House of Delegates meeting for the following five year period:

1976—Jekyll Island, April 9, 10 and 11
1977—Macon, April 22, 23 and 24
1978—Augusta, April 21, 22 and 23
1979—Savannah, April 20, 21 and 22
1980—Atlanta

President Wells announced that the new MAG Council and Executive Committee would hold their organizational meeting immediately and entertained a motion for adjournment sine die of the 121st Annual Session. The Final General Session adjourned at 2:45 p.m.

Official Attendance at the 121st Annual Session was:

160	Delegates
90	Members
116	Woman's Auxiliary
50	Guests
461	TOTAL

editorials
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editorials

New Officers Steer MAG

FLEMING L. JOLLEY, an Atlanta neurosurgeon, was selected as president-elect of the Medical Association of Georgia at the April Annual Session Business Meeting.

He has demonstrated his leadership abilities within MAG by serving in consecutive years as second vice president and first vice president. He has chaired the Traffic Safety and Emergency Medical Services committees and currently serves as chairman of Council.



MAG President-Elect Fleming Jolley, M.D., with grandchildren Catherine and William.

The Smyrna native was graduated from Marietta High School and Emory University School of Medicine. His internship and residencies were served at Piedmont Hospital and Emory University School of Medicine in Atlanta and City Hospital, Winston-Salem, N.C., and he was in the U.S. Navy from 1949 to 1951. He currently serves as associate professor of surgery (neurological surgery) at Emory.

Injuries resulting from automobile accident have been a special field of interest for Dr. Jolley, who has served as chairman of the Medical Advisory Committee and Driver License Advisory Board for the Georgia Department of Public Safety, and he has been a member of the AMA committees on Medical Aspects of Automotive Safety and Emergency Medical Services. He has prepared several scientific papers and published several articles on the subject.

Other professional affiliations include Fellowship in the American College of Surgeons, membership in the Southern Medical Society, The American Association of Neurological Surgeons and the Southern Neurological Society, of which is his treasurer and former vice president.

Dr. and Mrs. Jolley (Anne) have three children, Mrs. Ruthanna Bost, Lex, an ensign in the U.S. Navy and William, freshman at Georgia Institute of Technology.

Second Vice President

Columbus urologist James H. Sullivan now holds the post of second vice president of the Association. Dr. Sullivan attended Duke University, received a degree in pharmacy from the University of Georgia and his medical degree from the Medical College of Georgia. He has been in private practice in Columbus since 1964. Dr. Sullivan serves as a delegate from Muscogee County and has been a member of the State Board of Health.

AMA alternate delegates C. Emory Bohler of Brooklet and William F. Dowda

of Atlanta won seats as full delegates, succeeding J. W. Chambers and John S. Atwater, who did not seek reelection. Both Drs. Bohler and Dowda are former presidents of the Association. Joining them as delegates are H. Hilt Hammett, and William W. Moore. Dr. Hammett was first vice president in 1973, and is a LaGrange otolaryngologist who was graduated from Emory University School of Medicine. Dr. Moore, chairman of MAG's Committee on Insurance and Economics, specializes in neurological surgery in Atlanta. He is an Emory alumnus.

F. G. Eldridge of Valdosta, chairman of the Finance Committee, sought and won reelection as AMA alternate delegate and is joined by Charles Hollis of Albany. Dr. Hollis, an internist, has served the Association as chairman of the Committee on PSRO and as a delegate from Dougherty County.

PAIN PRESCRIPTION IS TO GET ACTIVE

Getting out of bed and leading a more active life is helping chronic pain sufferers to overcome their pain problems, an Emory University treatment program shows.

At the Emory Pain Clinic, relief of chronic pain is achieved through various techniques, one of which involves psychological counseling and behavior modification, according to Steven F. Brena, M.D., director, Emory Pain Clinic, and Irving P. Unikel, Ph.D., clinical psychologist on the clinic staff.

All patients are volunteers in the program, and are persons who have not been relieved by other medical and surgical procedures. Some have virtually "given up" and have begun spending most of their time in bed.

The comprehensive treatment program, lasting six weeks, includes some form of medical treatment such as "nerve blocks" administered weekly by a physician. In addition, patients receive weekly counseling in which they are given certain daily assignments to perform such as walking, golf, tennis, or household chores. Tasks which the patient has indicated he would like to do and enjoys doing are given precedence.

All patients understand that they must do active things for a prescribed amount of time in order to receive their nerve block or other medical treatment for pain relief, Dr. Unikel explained. He added that this is based on the well-known psychological principles of "operant conditioning" in which appropriate behavior is rewarded and maladaptive behavior does not achieve the desired goal.

Each week, as the treatment progresses, the patient is required to become progressively more active until some agreed-upon level of activity is reached which the clinic staff believes is suitable for the patient's needs.

More than 50 patients have completed the comprehensive treatment program in recent months, "and at least three-fourths of them have shown marked improvement," Dr. Unikel said. He cited many cases of patients who were formerly spending much of their time in bed or otherwise limiting their activities because of chronic pain, but who now feel well enough to do normal household chores, get involved in recreational activities, and even go back to their jobs.

"We are finding that this program, if carried through to a successful conclusion, results in patients experiencing less physical pain, an increased feeling of well-being, and greater personal happiness," Dr. Unikel said. "Once a patient has been rehabilitated, that is, learns to cope with his pain problem, long-term satisfactory results can generally be expected. By contrast, when treatment does not go beyond medical therapy, such as drugs or pain blocks, pain relief is usually temporary."

HANDICAPPED CHILDREN SERVED BY SCOTTISH RITE HOSPITAL

Scottish Rite Hospital for Crippled Children in Atlanta offers a full list of services by its medical staff for the handicapped child. Specialty clinics are held in pediatrics, otolaryngology, ophthalmology, psychology, cardiac, neurology, allergy and immunology, neurosurgery, urology, pediatric surgery, plastic surgery and hematology.

Sub-specialty clinics in orthopaedics also are held for foot, hand, hip, amputee, spinal deformities, juvenile rheumatoid arthritis, myelomeningocele, neuromuscular, bone tumor as well as growth and metabolic and cerebral palsy.

A New-Patient clinic is held each Tuesday from 8 a.m. to noon. Following evaluation, the child is referred to the appropriate specialty or sub-specialty clinic.

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Whither Immunocompetence?

Z. L. OLKOWSKI, M.D., Sc.D., D. R. MURRAY, M.D. *and*
J. R. MCLAREN, M.D., *Atlanta**

During the past several years we have witnessed tremendous strides in clinical immunology and the importance of the immune system in the development and progression of neoplasms. There is a possibility of manipulating immune responses which may lead to tumor rejection.

Tumors possess specific antigens capable of eliciting both cellular and humoral responses. Cellular and possibly humoral immunity are believed to be responsible for tumor inhibition. Cellular immunity may be determined either in vitro (lymphocyte transformation, stimulated by mitogens, lymphocyte cytotoxicity, an assay for T-lymphocytes, colony inhibition assay), or in vivo (delayed cutaneous hypersensitivity reaction to the primary stimulus of an antigen, most often DNCB). Humoral immunity is measured most often by the demonstration of cell surface antigens (indirect fluorescent antibody technique), by complement dependent, antibody mediated tumor-cell cytotoxicity assay, and serum immunoglobulin determinations.

Principles of Clinical Immunology

Research in this field has led to a few principles which form the basis for modern clinical immunology, namely:

1. Tumor cells contain specific antigens which are not present in normal adult tissues.
2. Tumor specific antigens evoke a specific immune response in the host.
3. Cell-mediated immune surveillance usually prevents the development of a tumor.
4. An impaired immunocompetence is frequently associated with the development of neoplastic disease.
5. The subsequent degree of impaired immunocompetence following cancer therapy correlates closely with prognosis.

Experimental data from reliable laboratories have shown that impaired cellular immunocompetence is characteristic of the following tumors: skin (basal and squamous cell carcinoma), head and neck cancers, squamous cell cancer of the uterine cervix, melanoma, sarcoma, genito-urinary cancer, squamous cell carcinoma of the lungs, cancer of the esophagus, Hodgkin's Disease, and carcinoma of the breast. In the case of the breast cancer, however, data from different laboratories are contradictory. Our own studies on over 100 cases show that most of the patients are characterized by impaired immunocompetence before the surgery. Some of the patients, especially older ones, with carcinoma of the breast, show normal cellular immunocompetence, whereas their immunoglobulins show abnormal values. Furthermore, cellular immunocompetence of patients with lung, esophagus, genito-urinary, skin and uterine cervix cancer, frequently impaired before therapy

* The Robert Winship Memorial Clinic, Emory University School of Medicine, 1365 Clifton Road, N.E., Atlanta, Ga. 30322.

improves after the surgery or radiation therapy. Patients having stable or rising immunocompetence usually remain clinically free of disease. A subsequent fall in cellular immunocompetence often precedes clinically evident metastases by an average of eight weeks.

Immunotherapy, although disappointing to the present, hopefully will, with continued advances, become an important arm in the management of cancer. Why do tumors escape the host defense mechanisms? It may be due to the Hellstroms' blocking factor present in the host serum or to Old's "sneak through" mechanism or to impaired immunocompetence of the host.

Information Value

It has been established in many laboratories that the information on immunocompetence and tumor antigens (i.e. CEA and others) are of value to the patient and physician because it:

1. Offers an early evaluation of treatment results.
2. Points out the possibility of distant metastases even if they are not detected clinically.
3. May be a factor in treatment management.
4. Assists in selecting and following cases for immunotherapy.
5. Acts as a sentinel for possible recurrence.
6. May be part of the decision tree in subsequent patient care.

Remarks made by Pasteur's contemporaries when they challenged him are relevant to the cancer problem. "Louis, we are aware of the presence of microbes, but some other factor is present, otherwise all patients developing infection would die." ■

Highlights of Executive Committee

MAY 18, 1975

National Health Service Corps Physicians for Dawsonville and Lenox Areas: Endorsed the efforts of the county medical societies to recruit NHSC physicians for their areas.

Provider Participation Agreement: The state Medicaid agency has advised that all physicians who wish to receive reimbursement must sign a "Provider Agreement." This agreement requires that a physician submit proof of his speciality; it requires the physician to collect any applicable third party reimbursement for Medicaid; it requires the physician to choose the least expensive treatment for Medicaid patients; it prohibits billing for any services provided by the doctors' staff except injections given by a registered nurse. The Secretary, Earnest C. Atkins, M.D., responded to the Medicaid Agency expressing MAG's strong objection to this further infringement on the physician's right to practice.

GMCF/CHEC Program: It was announced that Mr. Lowell Foster of the Research and Development Section has been assigned part-time to the GMCF to head its CHEC program.

Health Service Area Designation: The six-area designation was discussed. It was reported that the greatest objection comes from the Columbus area which plans to seek review and reversal.

Proposed Optometery School at the Medical College of Georgia: MAG voted to go on record as opposing the establishment of the school.

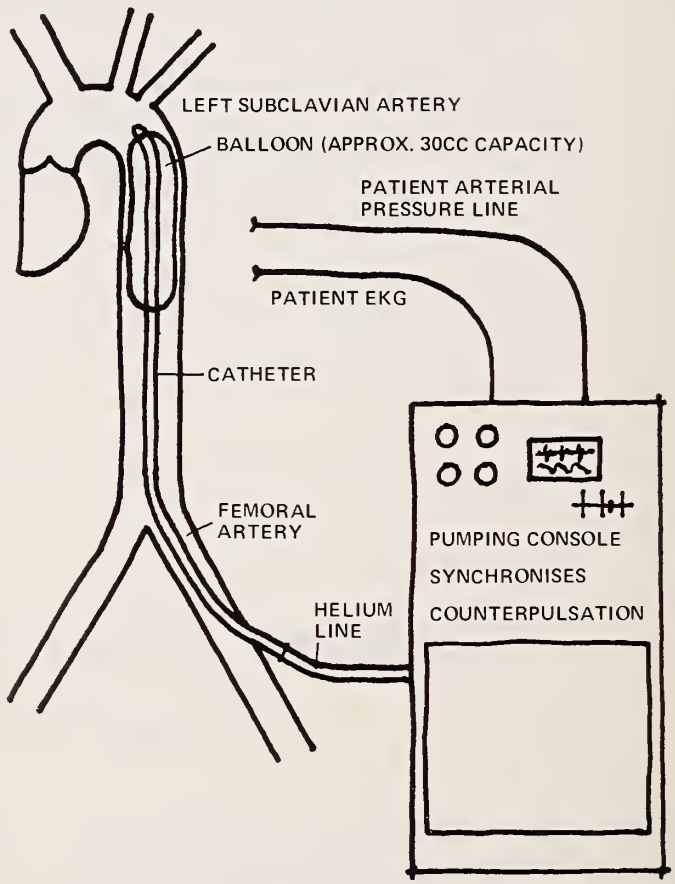
Appointments: Peer Review Committee—Walter S. Dunbar, Atlanta, to replace John R. McCain, who resigned, as chairman, and Richard Elmer, of Atlanta as vice chairman; Advisory Committee to Practical Nurses Examining Board—J. Rhodes Haverty, Atlanta; CHEC Advisory Committee: David A. Wells of Dalton.

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The Intra-Aortic Balloon Pump—What Does It Assist?

FRED D. ROSE, M.D., *Atlanta**

WITH THE ADVENT of coronary care units, mortality from acute myocardial infarction significantly decreased as a result of prompt and effective therapy of serious dysrhythmias. However, there was no parallel decrease in mortality from severe pump failure and shock secondary to myocardial infarction. A recent further advance was bedside monitoring of pulmonary artery wedge pressure in patients with hypoperfusion, allowing for identification of those with low left ventricular filling pressures whose shocklike state could be reversed by fluid administration. This still leaves a group of patients with myocardial infarction who develop cardiogenic shock with inadequate perfusion because the cardiac output is markedly reduced even though there is a high left ventricular filling pressure. This group has a reported mortality of 80 to 95 per cent despite drug therapy. It is these patients with cardiogenic shock in whom mechanical circulatory assistance is being clinically evaluated.



There are several types of mechanical circulatory assist devices for bedside use, but the one most frequently used is the intra-aortic phase-shift balloon. In this method a catheter-mounted cylindrical balloon is introduced into the femoral artery by surgical cutdown, and it is advanced to the proximal descending aorta.[1] A pumping unit synchronized with the patient's EKG rapidly fills the balloon (with helium or carbon dioxide) in early diastole and evacuates the balloon at the onset of systole. Thus, as the balloon inflates, it raises diastolic aortic pressure; and as it deflates, it lowers aortic systolic pressure. (See diagram.) The predicted effects of this phased balloon counterpulsation are:

1. Decrease in peak systolic aortic and left ventricular pressure. This allows

* Dr. Rose is the Associate Director of the Cardiac Catherterization Laboratory of Georgia Baptist Hospital and is in the private practice of cardiology at the Atlanta Heart and Lung Clinic, 272 Boulevard, N.E., Atlanta, Ga. 30312. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

less resistance to left ventricular emptying, an increase in cardiac output, and decreased left ventricular end-diastolic pressure.

2. Increase in aortic diastolic pressure with resultant increase in diastolic coronary filling.

The net result is decrease in left ventricular work (less preload and afterload), while at the same time increasing myocardial perfusion and peripheral perfusion.

Experimental animal cardiogenic shock has responded to circulatory balloon assist as predicted with consistent hemodynamic improvement. Likewise, in patients with cardiogenic shock, hemodynamic and clinical improvement has occurred in most reported cases.[2] We have observed a rise in arterial pressure, fall in pulmonary wedge pressure, increase in urine output, and reversal of infarction-induced bundle branch block patterns with counterpulsation. It would seem, then, that with balloon counterpulsation at last a significant reduction in mortality from cardiogenic shock would be noted. Alas, however, that is not the case, for the reported short term mortality still remains over 80 per cent despite balloon counterpulsation. Why this discrepancy between favorable hemodynamic response to balloon assist and yet no significant change in mortality?

Selection Criteria

The answer lies in the selection criteria used for balloon counterpulsation. Generally, patients selected for balloon assist have been in documented cardiogenic shock with oliguria, peripheral vasoconstriction, and clouded sensorium which has not responded to maximum (and sometimes prolonged) medical therapy with inotropic agents such as levarterenol or isoproterenol. Herein lies the difficulty because continued cardiogenic shock is a rapid vicious cycle, during which hypotension causes decreased coronary perfusion which causes increasing myocardial necrosis leading to more severe hypotension.[3] Add to this the effect of inotropic agents *on those patients who don't respond,* and there is even more myocardial oxygen requirement and more myocardial necrosis. One has then selected those patients with the worst possible myocardium in the beginning, added to it time delay required in instituting medical therapy, and compounded it by ineffective therapy which extends the degree of infarction. It should be no surprise that the mortality of such patients is not improved by balloon counterpulsation. Counterpulsation is only an assist device, and for it to be effective there must be a reasonable amount of functional myocardium. The inference that can clearly be drawn is that counterpulsation must be instituted at an earlier stage in order to evaluate any possible benefit.[4] A controlled study evaluating early counterpulsation and drugs in cardiogenic shock as opposed to medical therapy alone (rather than only after medical therapy fails) may well show whether or not there is long term improvement in mortality and cardiac functional capacity.

Complications of intra-aortic balloon counterpulsation are vascular insufficiency to the leg in which the arteriotomy is performed, decreased circulating platelets, thrombosis on the balloon with distal embolization, and damage to the aorta. Major contraindications are aortic regurgitation and severe femoral or aortic occlusive disease.

Indications

At the present time, indications for balloon assist counterpulsation are:

1. Temporary assistance following open-heart surgery when there is inadequate cardiac output immediately postoperatively. Results in this setting have been excellent.

2. Preoperative support for patients in intractable left ventricular failure prior to heart surgery.

3. Cardiogenic shock in myocardial infarction, unresponsive to medical therapy. It is this category which needs re-evaluation and perhaps a more aggressive ap-

proach. In selected cases, early counterpulsation may also be used to stabilize a patient in shock, until coronary angiography and coronary bypass surgery can be performed.[5]

In summary, intra-aortic balloon counterpulsation has been shown to be effective hemodynamically in cardiogenic shock and intractable left ventricular failure. Its use pre- and postoperatively in cardiac surgery is well established. In cardiogenic shock due to myocardial infarction, balloon counterpulsation will have to be evaluated earlier in the shock state in order to determine possible long term benefit. ■

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3. Sanders, C. A., et al.: Mechanical circulatory assistance; *Circ.* 45:1292, June 1972.
4. Goetz, Robert H., et al.: Unidirectional intra-aortic balloon pumping in cardiogenic shock and intractable left ventricular failure; *Am. J. Cardiol.* 29:213, Feb. 1972.
5. Mundth, E., et al.: Circulatory assistance and emergency direct coronary artery surgery for shock complicating acute myocardial infarction; *NEJM* 283:1382, Dec. 1970.

COURSE FOR PRECEPTORS OFFERED AT UNICOI

A special course for private practice family physicians currently serving as preceptors, or those who hope to become preceptors, is being offered for a limited enrollment of 50 July 18-20, 1975 at Unicoi Lodge and Conference Center in Helen.

This is the first time the School of Medicine of the Medical College of Georgia has offered such a course, which hopefully will be held twice a year in the future, designed to develop the skills needed to be successful preceptors in training medical students and residents. Strong emphasis will be placed on the unique educational benefits personally received by those serving as preceptors.

The course has been approved for 10.66 hours credit in Category 1 of the Physicians' Recognition Award of the AMA. Approval has been requested from the American Academy of Family Physicians. The program includes discussions on approaches to improving interpersonal communications; medical records; levels of preceptorships; and an explanation of the family practice program at the Medical College of Georgia.

Included in the guest faculty will be private practice physicians Irving D. Hellenga, Toccoa, W. Lanier Nicholson, Hiawassee, and Clyde V. Tanner, Martinez. Also speaking will be M. Charles Adair, director of medical education for Floyd Hospital in Rome; Kenneth E. Holtzapple, chief of family practice service at Martin Army Hospital at Ft. Benning; Frank A. Moorhead, chief of Department of Family Practice at Ft. Gordon; Robert E. Reynolds, professor of preventive medicine and associate professor of internal medicine for Rush Medical School in Chicago; Jesse Q. Sewell, III, director of family practice at the Medical Center of Central Georgia in Macon; and Howard G. Vigrass, director of the family practice residency program at the Medical Center of Georgia in Columbus; several members of the Medical College of Georgia staff will speak, and the course director is William E. Lotterhos, professor and chairman of family practice at the Medical College.

Registration for the course is $125. For additional information contact the Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902.

HANDBOOK ON RETARDATION AVAILABLE

The second edition of the AMA publication, *Handbook on Mental Retardation,* is now available for distribution by contacting the Order Handling Department, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610. The cost in quantities of one to 10 is $2 a copy; 11 to 49 is $1.80 a copy; and 50 or more is $1.60 a copy.

The new edition is updated and emphasizes newer and important areas of knowledge and application. This is not a textbook but is intended to give an overview for physicians in practice, medical students and those members of the lay public interested in problems of mental retardation.

Recent Amendments to the Federal Election Campaign Act

J. WINSTON HUFF, *Atlanta**

MOST PHYSICIANS are probably familiar in a general way with the Federal Election Campaign Act of 1971, since this law was widely publicized in the televised Senate Watergate investigation and the ensuing criminal trials. The 1971 Act did several things: It placed limitations upon federal campaign expenditures for the use of the communications media; it limited the amount of contributions to and expenditures by a candidate and his immediate family in connection with campaigning for nomination for or election to federal office; it also required political committees to register and to make extensive reports about their activities, contributions received and expenditures.

Late in 1974, Congress amended the 1971 Act, and at the same time amended other portions of the Federal Code dealing with federal elections. In typical Washington fashion, Congress wrote a 50 page amendment to a 17 page law. It is impossible to detail all that the 1974 amendment contained, but a brief description of the more important changes may be of interest.

Federal Election Campaign Commission: The new law sets up a Federal Election Campaign Commission composed of eight members. Two are appointed by the President *pro tempore* of the Senate, two by the Speaker of the House and two by the President, and all must be confirmed by both Houses of Congress. The Secretary of the Senate and the Clerk of the House are *ex officio* members without vote. The purpose of the Commission is to administer the election law and assure compliance with it. It has jurisdiction of the civil enforcement provisions of the law. It has been given subpoena and investigatory power and can require such written reports and answers from candidates and political committees as it may prescribe. It has the authority to render advisory opinions when requested with respect to campaign activities. It has been given the power to go into federal court to seek injunctions against what it considers prohibited conduct. Its decisions may be appealed to the courts. Violations of a criminal nature are to be referred by the Commission to the Attorney General for criminal proceedings.

Political Committees: Under the 1971 law, all "political committees" (such as GAMPAC) had to file a registration statement with the Clerk of the House and the Secretary of the Senate giving information regarding officers, candidates being supported, list of banks used and the like. These requirements have been retained, except as to the place of filing these reports. The definition of a political committee has been broadened to include any "group" (I suppose that could be two people) which receives or disburses more than $1,000 during a calendar year for election purposes. A "contribution" is defined as just about anything more tangible than a friendly smile and a warm handshake, but it does not include volunteer services on behalf of a candidate nor expenses in a person's home. A federal office seeker must

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

designate one committee to serve as his "principal campaign committee," and a principal campaign committee (except for the national committee of a political party) can support only one candidate. The financial reports referred to below are now to be filed with the candidate's principal campaign committee and that committee must compile the information and send it on to the Election Commission.

Races covered: The offices to which the law applies are President, Vice President, Senator and Representative. The amendment eliminated from its coverage the election of delegates to a constitutional convention but the law still covers any federal general, special, primary or run-off election, a convention or caucus of a political party held to nominate such federal candidates, a primary election held for the selection of delegates to a national nominating convention and presidential preferential primaries.

Reports of Political Committees: The timing of the filing of reports of political committees has now been somewhat changed. However, these reports must still contain detailed information as to income and expenditures including the source of all contributions in excess of $100 and the recipients of the Committee's gifts. Quarterly and annual reports are required and also reports must be filed shortly before and shortly after each election. These reports are public records.

Limitations on Political Expenditures: No more than $10,000,000 may be spent by a candidate for Presidential nomination, nor more than $20,000,000 for election to the Presidency.

Senatorial candidates for nomination may not spend more than the greater of 8¢ for each person of voting age in the state or $100,000; and for election a senatorial candidate may not spend more than the greater of 12¢ per voting head or $150,000.

Aspiring Congressional candidates in states where there is only one Congressional District may not spend more than the limits above set forth for Senators; Congressional candidates in all other states may not spend more than $70,000 for nomination or for election.

Expenditures made by authorized political committees on behalf of the candidate count toward his permissible total. Certain additional expenditures may be made by national committees of a party in behalf of a candidate. Severe restrictions have been placed on the use of personal funds: $50,000 for the office of President or Vice President; $35,000 for Senator or for Representative from a single district state; and $25,000 in the case of all other Representatives.

Limitations on Contributions: No political committee, other than the principal campaign committee may make contributions to any candidate for the offices mentioned which exceed $5,000. National committees of a political party which serve as the Presidential candidate's principal campaign committee cannot give more than $5,000 to any candidate other than its candidate for President.

No individual may make contributions aggregating more than $25,000 to all federal candidates in any calendar year. You cannot give the limit in a pre- or post-election year and then make another contribution in the year of the election, because the law will deem both contributions to have been made in the year in which the election is held. You cannot give more than $100 in currency; you cannot make or accept a contribution in the name of another person. Also remember that corporate giving is prohibited. Those physicians who have incorporated their practice must make their contribution by personal check.

Serious criminal penalties may be imposed for violations of this law. If a physician intends to become active in any race for federal office (primary, general election or whatever) or is asked to take even an inactive part as a campaign committee member, he should consult his attorney to be sure the law is complied with. ■

I've told this before . . . .

(Ed. note: A well-placed blow solves more than one problem says author J. G. McDaniel, M.D. in this story from his days as a young medical student. We solicit contributions from all MAG members and their families and material should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

A Mad Dog

IN THE EARLY PART of the 1920's, I had just finished my freshman year in medical school and was working with peaches during the harvest season at Fort Valley, Georgia. I had done this for four or five summers. Most of us who worked were high school or college students with the exception of a few old pros who followed the fruit trade the year round.

As soon as it was learned that I was in medical school, the appellation of "Doc" was immediately bestowed and all medical or medically oriented problems were referred to me.

We were well into the season and on one hot July day the peaches were ripening fast and everybody was working as hard as he could. The wagons and trucks were stacking them up faster than we could get them culled and packed and into the refrigerator cars. There had been a sort of unwritten rule amongst us kids and "pros" that they couldn't bring them in faster than we could get them into the refrigerator cars. This particular day, however, we were nettled by the chides of some of the teamsters who complained in loud voices about having to stack baskets of peaches two and three deep on the loading platform.

During all this sweat and toil a nondescript black and tan hound dog staggered up the side steps, came a little way into the packing house and stood there, slobbering and snapping at imaginary objects. He had a dazed look in his eyes as though he could not see very well and when he ran into a basket or the leg of a table he would turn and bite it as he wandered through the packing shed.

He did not do this but a few times before some of the older citizens commenced hollering "MAD DOG" and began climbing up on top of the peach bins and platforms. As the old hound staggered around, others took up the cry and scrambled to safety. The boss came charging up and wanted to know what in the hell was going on. But one look at the dog sent him to the top of a stack of crates with great alacrity and he commenced calling for someone to kill him, but nobody had anything to kill him with. A few brave souls found some green peaches and commenced throwing them at him, but their aim was poor and before the boss could stop them, they hit other people more often than they hit the dog. The mad dog was bad enough.

Then the boss came to me and said, "Doc, you've got to kill that dog before he bites some of our friends or one of the mules." When I asked him how he proposed that I kill him, he handed me a hatchet. I immediately replied that this was not a big bad wolf in "Little Red Riding Hood" and that I was not about to tackle a mad dog with a hatchet. But he explained that I could walk along on the platform that ran alongside the peach bins the entire length of the sheds. Eventually, he said, he will wander under the platform . . . and something's got to be done.

I reluctantly took the hatchet and followed the crazed dog along on the platform. Finally he came directly under me. I knelt down on one knee, took dead aim, and gave him a good lick with the butt end of the hatchet. He dropped in his tracks and everybody was happy and felt a great sense of relief except me. The boss

told two of the hands to drag him off down into the peach orchard—and for everybody else to get back to work.

I went into the office and sat down alone for some 15 or 20 minutes and smoked a cigarette. The boss came in, sat silently at his desk for a little while, then said very gently, "Doc, there's work to be done."

When we knocked off for supper, an elderly black man came up to me and said, "Doc, I am Zeke and I live over yonder in that first house the other side of the orchard. I understand you killed old Blackie this evening." I told him that I had, but that he was mad, and that a mad dog always died a miserable death in two or three days. I was sorry that I had to do it, but he might have bitten somebody, etc., etc.

"Naw sur," Zeke said, "Blackie was just having a 'running fit.' He has them every few weeks and allus gets over them. . . . I musta spent $10 on medicine for him, but it don't do no good. . . . He shore was a good possum dog . . . but I don't blame you none, you done what you thought was right and I don't fault you."

It was a restless night for me. I did not sleep well. I saw Zeke several times after that, but never had a chance to talk to him. It could be that I was kinda avoiding him.

The next peach season found me back in Fort Valley at the same place. On about the second or third day several of us were sitting on the porch after work and I saw Zeke coming up the road. He spoke very cordially and said, "Doc, could I see you a few minutes?" I walked out in the yard where there were several chairs, sat down in one, pointed to another and told Zeke to sit down, but he chose to remain standing. "Doc," he said, "do you remember exactly where you hit old Blackie?"

I said, "Yes, I hit him exactly between the eyes with the butt end of the hatchet, a pretty good lick," then waited for him to go on.

"Well," Zeke said, "the reason I axed wus that 'bout two days after you hit Blackie, he come home and he ain't had a 'running fit' since and he treed more possums this past gone year than he ever has treed before." And Zeke went on, "I been a thinking with you here and all, if he wus to have any more of them fits, could I bring him up here and git you to hit him again?"

J. G. McDaniel, M.D.
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MAGAZINE DEVELOPS PROTECTION PROGRAM FOR DISABLED

A big problem disabled people have today is the high price they must pay for the special products they need—their wheelchairs, lifts, auto adaptive equipment, etc. Even more important to them, however, is that these products be well constructed and safe to use. Their lives depend upon it.

ACCENT On Living, a magazine serving disabled persons, performs a unique service in this area. The readers themselves provide a lot of the up-to-the-minute information on quality. According to editor Ray Cheever, readers are quick to report products and services which do not live up to their advertising claims. Through *ACCENT On Living*'s Consumer Protection Program, complaints about products and services are forwarded to the company concerned. This gives the company a chance to correct any misunderstanding. Should a product advertised in *ACCENT* get an exceptional number of complaints, and the company not take corrective action, further advertising from the company is refused. *ACCENT* features information to help the disabled lead fuller, more productive lives.

Each issue of *ACCENT* also features new products and services that are available to help handicapped people. A recent edition includes, among other things, information about the first dependable electronically guided automobile, a self-help manual for arthritis patients, news about a one-arm gun support for those who would still like to go hunting, and a device for putting on and removing stockings and socks.

ACCENT is the only magazine that will send a free subscription to any physically handicapped individual who can't afford the price. Information is available by writing to *ACCENT*, Box 700, Bloomington, Illinois 61701.

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SOCIETIES

The **Sixth District Medical Society** met May 28 in Thomaston, in conjunction with a continuing medical education program. Speakers included Don Obele of the Medical College of Georgia on "Skin Manifestations of Internal Diseases" and E. Clyde Kelly, M.D., on "Drug Eruptions." A panel discussion by dermatologists followed, designed to help physicians with problem patients.

The topic, "Curriculum Planning in Education," was explored by guest speaker Dr. Mary Scott at the May 19 meeting of the **DeKalb County Medical Society.** Dr. Scott is head of Curriculum Planning for Georgia State University. The Society will be able to operate its Tel-Med program another year thanks to a grant from DeKalb General Hospital and Citizens and Southern National Banks.

PERSONALS

First District

Gerald E. Caplan, director of diagnostic radiology at the Memorial Medical Center in Savannah, has been inducted as president of the Georgia Radiological Society. The group met May 9 for its annual meeting and spring scientific session at Hilton Head Island.

Second District

Charles C. Stewart of Donalsonville, long active in Boy Scouting, has been awarded the Silver Beaver award at the annual Suwannee River Area Council Boy Scout Recognition Banquet in April. Dr. Stewart serves as a member of the executive board of the council and as trustee.

Third District

Floyd C. Jarrell, Jr., of Columbus, has been elected president of the Medical College of Georgia School of Medicine Alumni Association. Dr. Jarrell is a 1946 graduate of the college, has held several offices in the alumni association and is vice president of the MCG Foundation Inc. Serving with him will be **Woodrow Goss** of Ashburn as president-elect, **Hoke Wammock** of LaGrange as first vice president, **Harvey M. Newman, III** of Gainesville as second vice president and

THE ASSOCIATION / Continued

Harold S. **Engler** of Augusta as secretary-treasurer. Members of the board of directors include **William C. Shirley**, Macon, **H. Calvin Jackson,** Manchester, **J. Render Turner,** LaGrange, **David A. Wells,** Dalton, and **Philip R. Bartholomew,** Atlanta.

Fourth District

William E. Silver, Chamblee, has been accepted as a Fellow in the American College of Surgeons and has been elected to a full Fellowship in the American Academy of Facial Plastic and Reconstructive Surgery.

Fifth District

David F. Apple, Jr., Atlanta, has been elected to the American Society for Surgery of the Hand. Dr. Apple, along with **Neal Marcus** and **Newton Clark,** was elected recently to membership in the American Academy of Orthopedic Surgeons.

Jonas Robitscher, J.D., M.D., served on the visiting faculty of the Fourteenth Annual Seminar in Psychiatry at Central State Psychiatric Hospital in Nashville, Tennessee May 28-29. Dr. Robitscher is the Henry R. Luce Professor of Law and Behavioral Sciences at Emory University.

Sixth District

J. G. Etheridge and **Beverly Forester** of Macon participated in a panel discussion on National Health Insurance before the Sixth District Nurses Association in late April.

Herbert Greenwald served on the faculty for the Wills Eye Hospital Oculoplastic Department's continuing education services April 25-26 in Philadelphia, Pa.

James Achord, Macon, has been appointed associate dean for clinical affairs and professor of medicine at East Tennessee State University College of Medicine in Johnson City.

Tenth District

The Southeastern Dermatological Association has elected **J. Graham Smith, Jr.,** of Augusta as president at the group's annual meeting in Nashville, Tennessee. Dr. Smith heads the Department of Dermatology at the Medical College of Georgia.

Edwin S. Bronstein has been appointed by Gov. George Busbee to serve as chairman of the Governor's Special Council on Family Planning. Dr. Bronstein is chief of maternal health and family planning for the Medical College.

C. I. Bryans, Jr. recently received the Gold Medal from the Minister of Health and the Education Medal, First Class from the Minister of Education of South Vietnam.

Mary Jo Carter, associate professor of medicine, infectious disease section of the Medical College, was invited to serve on the National Advisory Allergy and Infectious Diseases Council at a recent meeting in Washington, D.C.

A. B. Chandler has been appointed editor of *Haemostasis,* an international journal.

William B. Strong has been elected to membership on the executive Committee of the Section on Cardiology of the American Academy of Pediatrics.

DEATHS

Bernard Leonidas Shackleford

Former Medical Association of Atlanta president Bernard L. Shackleford, 86, died May 1. Dr. Shackleford had received many honors for his activities. In 1967 he received the Great Georgian Award; in 1968 the W. S. Beaver Award was presented to him as the most outstanding alumnus of West Georgia College; he appeared in the 1971 edition of *Community Leaders in America;* and he was honored by the Anneewakee Foundation of which he was a former president.

Dr. Shackleford was graduated from West Georgia College, earned his pre-med certificate at Mercer University and medical degree from the Medical College of Georgia. He had practiced in Atlanta for more than 50 years, serving for a time as president of the staff at Georgia Baptist Hospital.

He was active in the Second Ponce de Leon Baptist Church, the Capital City Club, Yaarab Mounted Patrol, the Masons, and was past president of the Atlanta Arts Association.

Survivors include his widow, Winnifred Madden Shackleford; daughter, Mrs. Waverly Brown of Atlanta; sisters, Mrs. Coney Chatham and Mrs. Emmett Stallings of Carrollton, and Mrs. Hope L. Hearne of Palmetto; and brothers, T. Lester Shackleford of Dalton and Frank Shackleford of Carrollton.

what has the mag done for you lately?

PROFESSIONAL LIABILITY INSURANCE COMMISSION: Your Medical Association, through its Legislation Committee, asked Governor George Busbee about the possibility of his appointing a blue ribbon committee to study the professional liability insurance problem as it exists in Georgia.

At the GaMPAC Brunch during MAG's April Annual Session, Gov. Busbee announced his plans to appoint such a blue ribbon committee, composed of members of the Medical Association of Georgia, the Georgia Bar Association, the Georgia Hospital Association, the state's insurance industry, the Georgia State Nurses Association and the public. This committee is to study the problem and bring to Gov. Busbee solutions for legislative implementation, or, if need be, executive order.

MAG feels this committee is the best approach to solving the professional liability insurance problem in Georgia.

One copy of the 1975 Yearbook will be mailed to each active member of the Medical Association with his August issue of the **Journal.**

This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office will be available by advanced order for $5 a copy. Non-members will pay $10 for the first and every additional copy.

Checks should be made payable to the Medical Association of Georgia. Copies that have been ordered in advance will be mailed out at the end of August.

1975 YEARBOOK ORDER FORM

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Womb to the Tomb

FLEMING JOLLEY, M.D., *Atlanta**

THE NAME OF THE GAME was National Health Insurance. The ballpark was the Ninth National Congress on the Socioeconomics of Health Care in Atlanta April 25-26, 1975. The grounds keepers (AMA and MAG) had the playing field in meticulously excellent condition.

As the initial gun sounded, the grandstand was not too well filled. It improved as the day proceeded. A good section of Georgia State University representation was on hand. A sizeable portion of the crowd was from the private sector of the insurance industry. Scattered amongst these and other health folks could be seen Drs. Harrison Rogers, Billy Huger, John Gamwell, Julian Quattlebaum, Richard Colvin, Rhodes Haverty, John McCain, a nice young doctor from Dublin, and perhaps a few others whose names fail me at the present.

Batting practice comprised the morning session. The local can of pitchers, whom I thought individually did an excellent job tossing questions, were Bob Ketchersid, Hal Gulliver and Charles Seabrook. A. Jerome Brazda, *Washington Report on Medicine and Health,* seemed well acquainted with the batters in the panel box. Marvin Rowlands, Jr. seemed comfortable at first base. One question locally delivered on malpractice was either ruled a ball or a passed ball.

Major League Panel

Immediately the final score was apparent. There will be some type of National Health Insurance. Each batter, but one (Eugene Sibery of Blue Cross) had his own game plan. It was a major league panel including Max H. Parrott (AMA), L. A. Hill (AHA), L. P. Hemry (Health Insurance Association of America), W. B. Goldbeck (Washington Business Group on Health), D. E. Sibery (Blue Cross), James D. Knebel (Blue Cross), and E. G. Marshall (Committee of 100). Each had his cake. Compromise on the various methods (legislative bills) obviously has not been accomplished.

Mr. Marshall (Womb to Tomb proponent) was swinging away with the Kennedy bill. Quality care with access for all, unlimited coverage, and paid for by an escalating taxation program seemed to alleviate any type of private practice. There seemed to be some freedom of choice in selection of the doctor, however. Obviously the Health Services Act and the Health Manpower Bill are necessary to this approach with consumer dominance in regulatory mechanisms.

Collectively, the private sectors maintained an existence with modifications to improve current insurance coverage plans with federal and state support to those underprivileged in their income. The employer is goaded even more.

The seventh inning stretch came with a fine lunch. We needed that. To some extent it was unfair. The afternoon session was more of a sparring match in three rounds dealing with benefits and physician reimbursement, financing and administration, cost controls and quality assurances. The adrenalin was enhanced by one Eugene Sibery of Blue Cross. He has not chosen up sides yet.

By the end of the second session, my notes again seemed somewhat disjointed. However, it seems that inflation has accounted for 50 per cent of the rise in cost. Health Care Systems and Health Service Systems do not mean the same thing. As long as there is philanthropy to give money, this money should not affect percentile of federal or state financial provisions. Certificate of need on a statewide basis is running about 10 states behind ERA. Private insurance companies cannot currently share the uninsurable. Basically I think you can make more profit on selling "good apples than rotten apples."

I skipped the "nineteenth hole" Friday evening.

On Saturday morning, the grandstand was less filled. Obviously, as one Atlanta newspaper editor indicates. Saturday is "for remembering."

Projected Caricatures

My vote was that this was the heavyweight session. Dr. John Zapp, AMA-Washington, outlined the congressional makeup with projected caricatures (slides) of the men involved in Congress. Sen. Herman Talmadge (attorney, farmer, and politician) led off comfortably. Rep. Tim Lee Carter, an exiled "rural" physician from Kentucky, sacrificed Mr. Talmadge into scoring position. A pinch-hitter from North Carolina, Rep. James G. Martin, proved to be the flashy, fielding short-stop. Rep. Dan Rostenkowski must have been "minding the store." Martin, an ex-college professor of chemistry, was as sharp as Lee Trevino with a three stroke lead on the 72nd hole.

It was obvious that Congress, despite reorganization in the House, is more encumbered at this point in time with the deficit budget that doesn't make MAG's sound like a half-drop in the bucket.

Sen. Talmadge was refreshing in his continued support of separating the H from the E and likewise the W from the E. His support of the physicians was reiterated. Though public fiscal and quality accountability is demanded and to be had, he maintains the physician should be the peer review. He emphasized that if the doctors were *not* willing, someone else would supervise this assurance.

A designated hitter completed the conference. Dr. Theodore Cooper (M.D. and Ph.D.) represents us physicians in the bureaucracy of HEW. I liked the way this gentleman delivered. Private medicine is fortunate to have a real doctor in this capacity. I agree one needs to be careful in his assessment of the academician (former professor of surgery at St. Louis University). Interestingly, he reviewed what was said to be the initial hearings and recommendations of congressional hearings chaired by a physician-congressman on National Health Insurance in 1932.

The proceedings of this Socio-Economic Congress will be ultimately available. Direct the individual requests to Mr. William M. Cohan, Department of Health Insurance, AMA home office in Chicago. ■

* Dr. Jolley is president-elect of MAG. His practice in neurosurgery is at Emory University Clinic, Atlanta, Ga. 30322.

The Month in Washington

The American Medical Association has introduced a new proposal for national health insurance into the U.S. Congress. Key lawmakers on both sides of the aisle in the House of Representatives are sponsors of the bill—HR 6222.

The AMA proposal is the only substantially new approach to national health insurance (NHI) presented so far in the 94th Congress. Called the Comprehensive Health Care Insurance Act, the bill was introduced into the House by Reps. Richard Fulton (D—Tenn.); Tim Lee Carter (R—Ky); John Duncan (R—Tenn.); and John Murphy (D—N.Y.).

The AMA's NHI plan builds on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65 per cent of the cost. Employees would not be compelled to participate. The self-employed as well as the non-employed could purchase qualified private health insurance, through pools if needed, at a cost not more than 125 per cent of the cost of group plans. They would have all or part of the premium paid for by the federal government depending upon their income tax liability.

Small businesses that find the mandated plan an added financial burden would receive federal assistance.

Medicare beneficiaries could purchase supplemental insurance to bring Medicare benefits to a par with those offered elsewhere, with the government assisting people with limited resources. Medicaid would be eliminated under the program.

After a certain level of co-insurance is reached, depending upon income, insurance covers all remaining costs as a complete protection against catastrophic costs.

The co-insurance factor would deprive no one of needed care, sponsors said. The absolute maximum that any individual would have to pay would be $1,500; the absolute maximum for any family would be $2,000 in any given year.

Evolution of Thinking

Fulton, a member of the House Ways and Means Committee, told the House that the bill "represents the evolution of the doctors' thinking on this complex subject; and it demonstrates that the continuing process of discussion and debate has influenced the doctors as, indeed it has influenced the thinking of Congress."

"We must build on the structure of group health insurance which is today providing sound basic coverage for a vast majority of Americans at no cost to the government," said Fulton. "It is easier to remedy whatever deficiencies exist in this mechanism than to junk it in favor of a new and elaborate government structure that would have to be created from scratch . . . it would also be considerably less traumatic for Americans to remain with a familiar system. . . ."

Rep. John Duncan, third ranking Republican on the House Ways and Means Committee, said in a House speech that "the AMA plan does the best job to date in identifying the line between national bankruptcy and national parsimony in expenditures for national health insurance.

"The doctors' plan provides federal assistance on the basis of need. The most help goes to those who need it most. The least help goes to those who need the least."

He said the Comprehensive Health Care Insurance Act removes the fear of catastrophic illness that plagues even well-off Americans and provides sweeping regular benefits, including 365 days of inpatient hospital care, 100 days of skilled nursing care, full dental care for children, home health benefits and many other services including psychiatric treatment and well-baby care.

Rep. Tim Lee Carter, a physician-member of Congress and ranking minority member of the House Health Subcommittee, said the bill "retains a large measure of pluralism in the administration and financing . . . and it is precisely this pluralism—the creativity and sensitivity of the private sector, supplemented only where necessary by government—that has made the quality of American medicine hands-down the finest in the world."

Dr. Carter pointed to the cost control mechanism of "co-insurance" (except for the poor) in the physicians' plan. "There is incontestable evidence that any health care system without some regulatory control is soon bogged down by the 'worried-well,'" he said.

Rep. John Murphy of New York, a member of the Commerce Committee, said, organized medicine's plan "does about what the federal government can afford to do at this particular time. It will not be legislation that overpromises and underperforms."

The lawmaker denied "that any form of national health insurance is preferable to what we have. The right kind of program can accomplish much; the wrong kind could actually do harm."

"The need is immediate," declared Murphy. "Because the program utilizes the existing structure of the private insurance industry, there can be a fast start-up. There will be a minimum of administrative costs and bureaucratic delays.

"This is the place to start: a sound foundation of comprehensive health services, available to all Americans, and at a reasonable cost."

Professional Liability Crisis

The AMA has told Congress that federal legislative remedies for the professional liability crisis could create a worse situation and in some cases result in even higher liability costs.

Testifying before the Senate Health Subcommittee headed by Sen. Edward Kennedy (D—Mass.) as it opened hearings on the liability issue, AMA President Malcolm C. Todd, M.D., declared "it is far wiser for states to enact varied innovative legislative responses to the problem than to have an untested and unproved scheme enacted on a nationwide basis by the federal government, particularly where such proposals contain

elaborate provisions for federal government regulation of the practice of medicine."

Dr. Todd, accompanied by Richard E. Palmer, M.D., Chairman of the AMA Board of Trustees, said there's no question a crisis exists in medical liability insurance. "The complexity of the problem, and its varied causes convince us, however, there is no single solution, be it arbitration, 'no-fault,' or anything else."

Many states are acting on the liability problem, Dr. Todd pointed out. "Perhaps the eventual solution in most states will be a synthesis of various approaches. . . . Enactment of a federal program would eliminate the state's initiative and would establish a program that would fail to recognize individual state problems," he said.

One of the bills before the Subcommittee proposes compulsory arbitration tied to licensure and relicensure of physicians, review of all physicians' services by Professional Standards Review Organizations (PSRO's), acceptance of federal fee schedules under Medicare and required consultation before surgery. These restrictions "have no demonstrated relationship to the problems of medical liability or liability insurance," Dr. Todd told the Subcommittee. "Rather the crises-need for remedies for these problems is being used as a device for imposition of further government meddling in the practice of medicine."

A somewhat surprised Sen. Edward Kennedy (D—Mass.) has encountered a wall of opposition from the major groups involved in the medical liability crisis with respect to federal intervention as a solution. The Administration has joined the AMA, the American Hospital Association, and the American Trial Lawyers Association in urging that the federal government keep out of the liability picture at least for the time being.

Most of the suggested remedies so far carry bad news for some group, either increased governmental controls on physicians and hospitals, loss of fee income for lawyers, or some undermining of medical consumers' right to sue. In addition, insurance has always been very much a state prerogative in this country and federal legislation that infringes on states' powers over insurance is always difficult to enact.

In the absence of a clear and unequivocal call from some segment of the affected public and professions, the likelihood of Congressional action this year on a broad liability bill appears remote. An undercurrent of opinion on Capitol Hill seems to be that the problem should be faced when a national health insurance program is considered.

Medicare Reimbursement

An Administration proposal to tie physician reimbursement for Medicare patients to levels related to but under "cost-of-living" indexes has drawn an angry protest from the AMA.

The new payment plan would carry out a provision of the Social Security Amendments law passed in 1972 which tied physicians' reimbursement under Medicare to economic factors geared to a cost-of-living index. Health, Education and Welfare Department Secretary Caspar Weinberger said the proposed regulations were drafted "so that Medicare costs will follow rather than lead inflationary trends."

Richard E. Palmer, M.D., Chairman of the AMA Board of Trustees, charged that there is an "appalling lack of the most elementary and essential information" about the proposal, which he termed "another federal attempt to cop out on previous commitments to the elderly and to shift most of the burden onto the individual patient and the physician."

Thirty days were given by HEW for interested parties to comment on the proposed regulation published in the Federal Register on April 14.

"We have been given just 30 days to respond to a whole new set of HEW regulations to put a lid on Medicare reimbursement rates," Dr. Palmer said. "Since the proposed regulations relate to a law passed over two years ago, we think we are entitled to a minimum of 60 days to examine them and reply.

"Key parts of the regulations are not even available. HEW has offered examples of how the new regulations might apply. But we do not know where the data comes from nor how they were developed.

"These regulations apply to no other segment of the economy. They involve price rollbacks to 1971 levels They also seem to be designed to save Medicare expenditures without regard to the possible impact on other segments of medical cost."

Federal Appointments

President Ford has nominated Theodore Cooper. M.D., as Assistant Secretary for Health at the HEW Department. The post is the most powerful health job in the federal government.

Dr. Cooper succeeds Charles C. Edwards, M.D., who resigned January 5. A native of Trenton, N.J., Dr. Cooper, 46, has been serving as Acting Assistant Secretary. He is a physiologist, pharmacologist and surgeon.

Ford also nominated Donald S. Frederickson, M.D., as Director of the National Institutes of Health. Dr. Frederickson, 50, replaces Robert S. Stone who resigned January 31.

Dr. Cooper has served as Chief Deputy to Dr. Edwards following a stint as head of the National Heart and Lung Institute. He is regarded as a capable administrator whose close ties to the scientific-academic community will help him.

Dr. Frederickson also served as Director of the National Heart Institute and had been a member of the NIH scientific staff since 1953. He is an authority on fat transport in the circulation and on the disease of lipid metabolism.

A measure sponsored by the AMA to remove inequities and confusion over incentive pay bonuses for federal medical officers has been introduced in Congress.

The bill would amend the law to enable all medical officers in the uniformed services to be eligible for the special pay bonus upon entering into active duty.

The incentive pay could be reduced or adjusted to reflect amounts that the federal government had already paid or any benefits which have already been received by medical officers prior to the commencement of their active duty. Introduced by Rep. Thomas Downey (D.—N.Y.), the bill applies to the military and the Public Health Service Commissioned Corps. There have been many complaints that the bonus provisions have led to instances where junior men were receiving higher pay than veteran superiors. ■

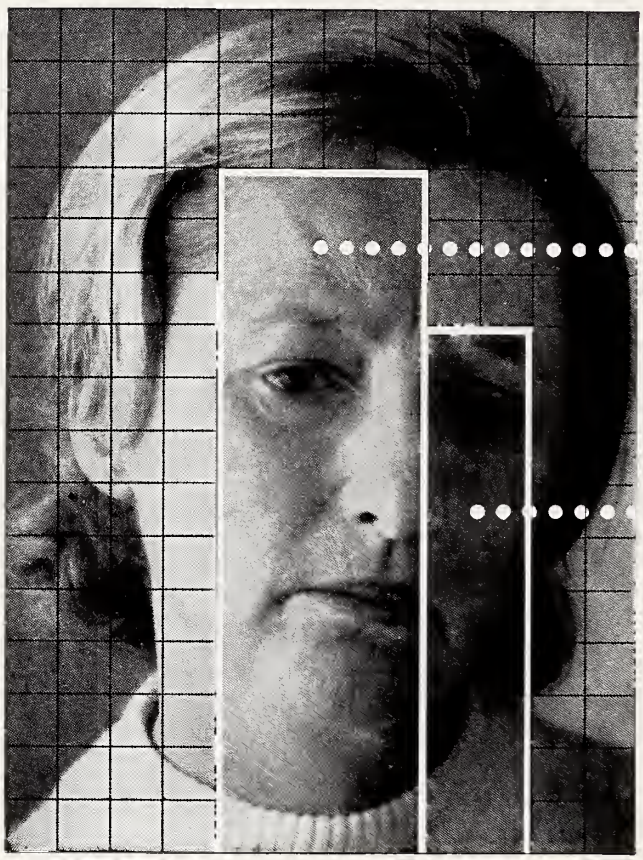
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CHEC (chĕk), n. [acronymn for Certified Hospital Extension of Care] A concurrent utilization review control program which places the authority for decision making in the hands of physicians at the local hospital level. *(See Page 261 and Editorial Page.)*

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freque and/or severity of grand mal seizures require increased dosage of standard convulsant medication; abrupt withdra may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous gestion of alcohol and other CNS depre sants. Withdrawal symptoms (similar t those with barbiturates and alcohol) h occurred following abrupt discontinua (convulsions, tremor, abdominal and m cle cramps, vomiting and sweating). K addiction-prone individuals under care

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Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

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Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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THE COVER

The workings of the CHEC program, which will be implemented August 1, are explained by CHEC Committee Chairman Richard A. Griffin, M.D. in an article on page 261, and endorsed in an editorial by Earnest Atkins, M.D. on page 280. Cover by Bob Hamill, Atlanta.

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CHEC: Statewide Implementation for Medicaid

RICHARD A. GRIFFIN, III, M.D., *Cartersville**

EFFECTIVE AUGUST 1, 1975 the Georgia Medical Care Foundation's CHEC program will be implemented state-wide for all Medicaid patients in hospitals electing to participate in CHEC. Non-CHEC hospitals will be required to submit to Medicaid medical records of all stays in excess of established review dates; these records would be subject to retrospective review by the Georgia Medical Care Foundation.

The CHEC program places the authority for decisions as to medical necessity and appropriateness where it properly belongs—in the hands of the Utilization Review Committee physicians representing the medical staff of the local hospital. The Georgia Medical Care Foundation—through its CHEC Committee—will assist hospitals in establishing this review procedure, and will be responsible for monitoring the effectiveness of this review. Hospitals whose concurrent review programs are judged effective by the CHEC Committee will be designated as CHEC waiver hospitals; the Georgia Medical Care Foundation will not recommend denial of payment of daily room charges for any days certified by a CHEC waiver hospital. Thus, the CHEC program significantly lessens the financial impact of retrospective denial of payment for hospital services already rendered.

The pivotal role in the operation of CHEC in each hospital is that of the physician advisor. He is appointed by his hospital u.r. committee and should be—if possible—a member of that committee. Whenever a review question requiring medical judgement arises, it is the physician advisor who must make that judgement. It is the policy of the Georgia Medical Care Foundation to reimburse physician advisors for time spent in performing concurrent review.

* Dr. Griffin, a member of the Georgia Medical Care Foundation Board of Directors, serves as chairman of the CHEC Committee. His address is P.O. Box 764, Cartersville, Ga. 30120.

An explanation of the CHEC program and review of its procedures is given.

The physician advisor is assisted by a non-physician utilization review coordinator employed by the hospital. The u.r. coordinator performs all those duties associated with concurrent review (assignment of review dates, receipt of requests for extension, abstracting of the medical record, etc.) which do not normally require medical judgement. The u.r. coordinator may refer to the Georgia Utilization Review Resource Material distributed by the Georgia Hospital Association; however, whatever criteria source is utilized, the review must be accomplished at least two days prior to the review dates shown in the Georgia Utilization Review Resource Material.

It is the u.r. committee which bears the responsibility for assuring the effectiveness of its concurrent review program. This may be done through the appointment of qualified physician advisors, the maintenance of a fair and timely appeals procedure (the u.r. committee is the appellate body for CHEC), and strict adherence to the following required procedures:

Admission Certifications

At the time of admission, the admissions office will provide the u.r. coordinator with at least the following information: patient name, status of Medicaid eligibility, and room number.

The u.r. coordinator will review the chart of each patient within 24 hours of admission.

1. If according to criteria furnished by the u.r. committee, admission appears necessary to the u.r. coordinator, she certifies the appropriate number of days according to the diagnosis

given by the attending physician and places a certification sticker on the chart.

2. If, however, the u.r. coordinator is unable to certify the admission, she refers the case to the physician advisor.
   A. If admission appears necessary, the physician advisor certifies the appropriate number of days.
   B. If admission does not appear necessary, the physician advisor notifies the attending physician of his intention to deny certification.
      (1) If the attending physician provides additional information during that working day, and if—based on this additional information—admission appears necessary, the physician advisor certifies the appropriate number of days.
      (2) If the attending physician does not provide additional information during that working day, the case is automatically appealed in the name of the attending physician to the utilization review committee (or a subgroup or designee of the committee).
         (a) If admission appears necessary, the u.r. committee (or subgroup or designee of the committee) certifies the appropriate number of days.
         (b) If admission does not appear to be necessary, the u.r. committee's (or subgroup's or designee's) denial is a final determination. All denial notifications must be confirmed in writing within 24 hours and copies go to the patient, attending physician, hospital administration, and the state agency.
      (3) If the attending physician provides additional information during that working day, and if—based on this additional information—admission does not appear necessary to the physician advisor, the case is automatically appealed in the name of the attending physician to the u.r. committee (or a subgroup or designee of the committee).
         (a) If admission appears necessary, the u.r. committee (or a subgroup or designee of the committee) certifies the appropriate number of days.
         (b) If admission does not appear to be necessary, the utilization review committee's (or subgroup's or designee's) denial is a final determination. All denial notifications must be confirmed in writing within 24 hours and copies go to the patient, attending physician, hospital administration and the state agency.

Extension of Certification

The u.r. coordinator will review the chart of each patient at least two days prior to the date certification expires. If, according to criteria furnished by the u.r. committee, further stay appears necessary, the u.r. coordinator may certify additional days (not to exceed three). However, if the u.r. coordinator is unable to certify additional days, according to the criteria, she will place a request for extension in the patient's chart for the attending physician to complete if he feels further stay is necessary.

Request for Extension

1. If, upon receipt of the request for extension, further stay appears necessary in accordance with the criteria furnished by the u.r. committee, the u.r. coordinator certifies the appropriate number of additional days (not to exceed three).
2. If, however, the u.r. coordinator is unable to certify additional days, she refers the case to the physician advisor.
   A. If further stay appears necessary, the physician advisor certifies the appropriate number of days.
   B. If further stay does not appear necessary, the physician advisor notifies the attending physician of his intention to deny the request for extension.
      (1) If the attending physician provides additional information during that working day, and if—based on this additional information—further stay appears necessary, the physician advisor certifies the appropriate number of days.
      (2) If the attending physician does not provide additional information during that working day, the case is automatically appealed in the name of the attending physician to the u.r. committee (or a subgroup or designee of the committee).
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HIGHLIGHTS OF EXECUTIVE COMMITTEE
June 7, 1975

Locality Reimbursement Differential: Received the legal opinion from MAG Counsel that reimbursement differential based on geographic locality is in fact in the law and would be difficult to challenge. Any challenge to be made would have to be directed at the geographic boundaries as established by Prudential.

SEER Program Proposal: Adopted a motion calling for MAG to withdraw its SEER proposal and to support an acceptable program if presented by another group.

Meeting with Insurance Commissioner: Received a report from the President, Dr. David Wells, of his attendance at an informal meeting with the Insurance Commissioner, Johnny Caldwell, on the subject of professional liability insurance. Also in attendance at that meeting were representatives of the Georgia Bar Association, the Georgia Hospital Association, and the State Legislature. Dr. Wells reported a feeling of cooperation among the different groups and with Commissioner Caldwell, who agreed to meet with this same group again at a later date to discuss any problems which may arise in the interim.

Governor's Commission on Professional Liability Insurance: At the request of Governor Busbee, two names of individuals to represent MAG have been nominated to serve on this commission. They are Robert E. Wells, M.D., Atlanta and Charles D. Hollis, Jr., M.D., Albany.

More on Professional Liability Insurance: Adopted a motion specifically directing the Professional Liability Committee to return to the next Executive Committee meeting with specific reports on recommendations of the Committee or an official position of MAG regarding alternatives for malpractice insurance and legislative changes based on the list of ideas from other states.

Georgia Hospital Project: Approved MAG as cosponsor of this project.

Ad Hoc Committee on Criteria Development for Hospital Utilization Review: Disbanded this committee and assigned its responsibility to the newly appointed Foundation CHEC Committee.

Committee Appointments: Committee on Emergency Medical Services—Lester Haddad, Savannah; Emile G. Abbott of Conyers, Ronald P. White of Albany; and LeWayne Lambert of Augusta (contingent on MAG membership). Committee on Membership—Milton Frank, III, Atlanta, and Thomas R. Nolan of East Point. Chairman of the Committee on Allied Health—J. Rhodes Haverty, Atlanta. Committee on Professional Conduct and Medical Ethics—A. Cullen Richardson, Jr., Atlanta. Committee on Peer Review—Julius Ehik, Atlanta. Chairman of the Committee on Medicine and Religion—John W. Walker, Decatur. Chairman of the Committee on Third Party Relations—Charles D. Hollis, Jr., Committee on Legislation—Judson L. Hawk, Jr., M.D., Atlanta.

what has the mag done for you lately?

YOUR KEOGH PLAN: In the past, the maximum contribution for one participating in a Keogh Plan Pension Reform Act was 10 per cent of one's net income from practice, or $2,500, which ever was less.

Through Federal legislation this was changed and affected only those states which adopted this federal law. During the 1975 Georgia General Assembly, legislation was passed, at MAG urging, adopting the federal law which permits Keogh participants to deduct the new limitation—the lesser of 15 per cent of net income or $7,500. Thus, under the new rules, a physician whose net income is at least $50,000 could adopt or revise a Keogh plan to provide for $7,500 annual contribution for himself.

The Georgia law adopts this change and makes it retroactive for 1974.

An eminent authority gives his report on the cancer control problem in Georgia since 1937.

Historical Background of Cancer Control in Georgia

HOKE WAMMOCK, M.D., *LaGrange**

IN ORDER TO COMBAT the cancer problem, the Georgia Department of Public Health officially entered the field of cancer control in 1937 when the state legislature passed a cancer law making it mandatory for the department to provide facilities for the treatment of indigent cancer patients. On October 1 of that year a Division of Cancer Control was established in the department.

A cooperative arrangement which was set up for the purpose of developing a smooth working relationship between the Medical Association of Georgia, the Department of Public Health, and the Georgia Division of the American Cancer Society was highly effective and became a model for many other states. An Executive Committee of the Cancer Commission acts in an advisory capacity to the Cancer Control Service for the Georgia Department of Public Health. The same group plus additional members acts in an advisory capacity to the administrative officers of the Georgia Division of the American Cancer Society. Thus the activities of all interested groups are coordinated without overlapping services, and this was the birth of the Committee on Cancer of the Medical Association of Georgia.

State-Aid Clinics

Following the organization, a survey was made of existing facilities in the state. In addition to the organized clinics, certain facilities (such as varying amounts of radium and deep x-ray therapy units) were available in a few areas in Georgia.

Regulations were established under which state-aid clinics would be approved. These were essentially similar to the minimum requirements recommended by the American College of Surgeons. Clinics were approved as soon as they were able to meet the requirements. Under the state-aid cancer program, some 22 clinics in the state of Georgia qualified to receive state-aid funds.

It was also necessary to establish the conditions of approval for state-aid. It was decided to have the local family physician make application for state-aid on an official form and certification as to eligibility was to be made by the county welfare department. The administrative aspects concerning the referral of patients was assigned to the Division of Cancer Control. With reference to payment for clinic services, it was decided that the staff physicians would donate their services free of charge and other services would be paid for at cost. A committee was appointed to work out a schedule of fees for certain hospital services, x-ray examinations, radium and x-ray therapy.

In 1937 by Legislative Act the sum of $100,000 was appropriated for cancer control and 1,419 patients received medical care for that year. Since the inception of the program in 1937, the State Legislature has appropriated additional funds up to $560,-192 for the year 1965 and a total of 4,556 patients received medical care. From that period of time to the present, the funds have dropped down to $400,-000. In 1966 Medicare and 1967 Medicaid was enacted into law. As a result of this, there was a drop off in the number of indigent patients being referred to the state-aid cancer clinics. The patient load in the state-aid cancer clinics dropped down to 2,365 in 1971.

GRMP Emerges

Public Law 89-239, 89th Congress, S. 596, October 6, 1965, was passed by Congress and signed by President Johnson. This law became known as the "Heart Disease, Cancer, and Stroke Amendments of 1965" or the Regional Medical Program for Heart, Cancer and Stroke. This meant that aid for these ills would be available for all regions of the country,

* Chairman of the Committee on Cancer of MAG. Dr. Wammock is the director of the Enoch Callaway Center Clinic, Vernon Road, LaGrange, Ga. 30240.

and from here on this will be known as the Regional Medical Program and more appropriately the Georgia Regional Medical Program by virtue of the fact that the Medical Association of Georgia in agreement with the Medical College of Georgia and Emory University agreed that the Regional Medical Program should be operated by the members of the Medical Association of Georgia.

The Task Force reviewed the entire program in Georgia from every facet of cancer control; early detection, treatment, rehabilitation, epidemiology, and a whole gamut of cancer control activities including such agents as the Georgia Division of the American Cancer Society, the State Health Department, and the two medical schools.

We determined the availability of all physical facilities, diagnostic and therapeutic equipment, professional personnel and nonprofessional engaged in cancer control activities.

As Chairman of the Committee on Cancer, it was my privilege to have been a member of the Task Force that prepared the proposal that was presented to HEW and was approved.

A goal was set and out of this 12 clinics were designated as area cancer facilities.

The Committee on Cancer of MAG assumed certain functions delegated to it by agreement with the Regional Medical Program such as the operation of the Tumor Registry, and the development of educational programs, and the radiation center in Augusta. We were responsible for operation of part of the budget.

The Regional Medical Program on Cancer served in a most beneficial way and in a cooperative spirit in cancer control in Georgia.

In 1973 the funds for the operation of the Regional Medical Program were impounded by President Nixon, but by Court order in recent months the funds have been released, and the Regional Medical Program will be functional until September 1, 1975.

National Cancer Act

Law 92-218, 92nd Congress, S. 1828 was enacted into law in December of 1971 and became known as the National Cancer Act. This Act authorized the appropriation of $400,000 for the fiscal year 1972, $500,000 for fiscal year 1973, and $600,000 for the fiscal year ending June 30, 1974. These funds were to be used for cancer research centers and some 15 centers were to be designated as such at strategic points throughout the country.

Two cancer centers have been designated in the south, one at Duke University and one at the University of Alabama.

At this point it should be pointed out that one of the medical schools in Georgia filed a letter of intent for approval of a cancer center but this was not approved.

Thus we began in March a retrospective and a prospective study of cancer in Georgia for the development of a program to replace the Regional Medical Program and take up where it left off. The philosophy of this program was printed in the *Journal of the Medical Association of Georgia* in August 1973.

Cancer Management Network

In April of 1973 the groundwork was laid for the Georgia Cancer Management Network Program and an Advisory Council was selected which included various health agents, organizations, representatives of third party insurance carriers, consumers and others totaling some 70 individuals. From this was elected officers and an Executive Committee. A charter is now being drawn up for incorporation.

The Medical Association of Georgia in March of 1974 agreed to serve as fiscal agent for the Georgia Cancer Management Network to administer any governmental funds awarded to the Network. A resolution was presented to the Council of the Medical Association of Georgia at the May meeting in 1973. This was approved and is as follows:

> "The Committee on Cancer feels that the allocation of funds for cancer control in Georgia should be under the direct control of the Committee on Cancer of MAG as the governing body and representative of cancer control in Georgia rather than having funds allocated directly to either of the medical schools that we can operate the program in a more effective manner by utilizing the Committee on Cancer of MAG and also relying upon assistance from the Division of Physical Health of the Georgia Department of Human Resources for reducing costs."

In December of 1973 the Georgia Cancer Management Network submitted to the NCI an application requesting funds for six months support from January 1, 1974, to June 30, 1974, in the amount of $121,879 for the Georgia Cancer Management Network Program until we could formalize the Georgia Management Network Program but this request was denied. In the meantime the funds for the Regional Medical Program were released by Court order and became effective August 1974 until September 1975. We are now operating at the moment under the Georgia Regional Medical Program for Cancer Control in Georgia.

We were advised by the NCI that there would be no funds available for broad coverage for cancer

control for diagnosis and treatment but that grants would be awarded on a contractual basis and according to categories.

On January 25, 1973, a memorandum was sent to state and territorial health officers, Special Newsletter No. 73-2, stating that, "The National Cancer Institute is launching an extensive program of financial assistance for cancer control activities. There is $30 million available for fiscal year 1973 and $60 million is expected to be available in 1974."

It later developed that funds would not be available for financial assistance for cancer control activities. However, $4 million was funded to someone for such activities.

Accordingly we were informed that in view of the fact that there would be no funds available for statewide cancer control activities that grants would be awarded on the basis of category and on a contractual basis and not on an independent basis.

Requests for Grants

The following requests for grants were made:

1. Jan. 14, 1974: RFP No. NIH-NCI-CN-7417 "Prototype Network Demonstration Project in Breast Cancer." Proposal for a three-year contract totaling $2,127,640. (Approved)
2. Jan. 29, 1974: RFP No. NIH-NCI-CN-74-22 "Prototype Network Demonstration Project for Head and Neck Cancer." Proposal for a three-year contract totaling $581,589. (Not approved)
3. Aug. 20, 1974: A contract proposal for the Third National Cancer Survey (SEER) for metropolitan Atlanta and six surrounding counties for a 15-month period 10/1/74-12/31/75 at a cost of $302,121. This grant has not been approved.

It must be pointed out that the request for the breast project involves only 1,500 new cases annually of breast cancer. It does not cover other anatomical sites such as colon, rectum, cervix, lung, etc. Thus some 4,500 other new cases are actually left uncovered except to a very minimal degree under present funds that are now available through Division of Physical Health of the Department of Human Resources of Georgia.

At the present time the Division of Physical Health of the Georgia Department of Human Resources is making a retrospective and a prospective study of cancer control in Georgia with the hopes that there will be increased funds for total cancer control in Georgia.

On October 4, 1973, a meeting was held by Governor Jimmy Carter at which time he presented his program to those individuals interested or associated with health problems. This program was designated: "Georgia's Ten Major Killers and Cripplers." The budget prepared for cancer was $763,-636 which was to be added to the funds already allocated under the state-aid cancer program in the amount of $500,000, which would have brought the total budget to approximately $1,200,000. This was to be used for cancer control in Georgia. However, this program was not approved by an act of the Georgia Legislature in cutting the total budget for the operation of the state of Georgia.

Tumor Registry

Since 1955 we have had a rather active tumor registry operated by the state-aid cancer clinics or the area cancer facilities. The original support was given by the Georgia Division of the American Cancer Society and was withdrawn after some five or six years with the hopes that the hospitals would pick up the cost of the Tumor Registry.

However, when the Regional Medical Program became operative, we restructured the tumor registry program for the area cancer facilities and updated all of the tumor registries in the 12 area cancer facilities with funds from the Regional Medical Program.

However, when funds were withdrawn from the Regional Medical Program in 1973, the Division of Physical Health of the Georgia Department of Human Resources came to our rescue and made available the amount of $35,000 for the first year and $60,000 for fiscal year beginning July 1975.

After careful review of the Cancer Control Program in Georgia, it is difficult to see what is going to be accomplished under the so-called categorical award type of funding at the expense of abolishing the independent type of grant made in the past by the NCI. As evidenced by the foregoing information and this historical background, it is obvious that funds for cancer control are extremely limited at this time.

It is superfluous to state that cancer is the second leading cause of death in Georgia. For the year 1960 the total number of deaths from cancer was 4,371 and for the year 1973 the total number of deaths from cancer was 6,532. More than 20,416 will be under medical care for cancer, and approximately 12,000 new cases of cancer will be diagnosed in 1974. Lung cancer is Georgia's biggest cancer killer; 1,495 Georgians died of lung cancer in 1973.

It is obvious that we are at the crossroads in making positive and definite plans for cancer control with adequate financial support. This is why so much effort and time has been spent on documenting the input for cancer control since 1937 and where we stand today. ■

Poetry: An Avocation, Not a Hobby

"I thought to be a poet.
I felt I had his eye and ear,
If not his words;
I knew I had his heart."

RICH IN ANATOMICAL references, these few lines are the first words in a trim volume of poetry by Georgia's seventh and newest poet laureate, and hint at the profession by which he earns a living.

John Ransom Lewis, Atlanta plastic surgeon, learned he had been selected as speaker for the arts in Georgia when a telephone call from Gov. Jimmy Carter brought the news a few days before last Christmas. He takes his new role seriously and has elected to set aside one day each week for his efforts to promote poetry and literature in the state.

He comes from a family of physicians, lawyers and preachers with a strong literary and artistic bend that has found its blossoming in John Ransom Lewis. He is the son of a country doctor who doled out medical care and concern any time of the day or night he was needed. Payment was just as likely to be in chickens and fresh okra as dollars. Such an observation post on life fostered Dr. Lewis' later two-pronged career as poet and physician.

The poet laureate uses various styles in his writings depending on the subject matter, mood and audience. When writing for children, his words are apt to pounce to the edge of the page and mimic the prowl of the tiger he describes. He appreciates free verse for its ability "to say so much in a few words," but sonnets and ballads are frequently written and above all he considers himself a "17th Century poet."

Selecting a Poet Laureate

The search for the new poet laureate had begun a year before the final announcement, as Dr. Lewis was asked at that time to submit some of his poems for consideration. When Gov. Carter called with the appointment, "I told him I didn't feel very adequate, but I would enjoy trying and that I would accept if he wanted me to," Dr. Lewis says.

He was the one they wanted, the Governor explained. "My family and I have literally spent hours and hours reading poems by Georgia poets in the last year, trying to decide who would be our best poet laureate, and we have all decided you should be it," Carter told him.

The vacancy Dr. Lewis filled came with the death of Conrad Aiken, last poet laureate. Agnes Cochran Bramblett held the post before that and retired when



she no longer felt she could devote enough time and energy to it. Before her was Ollie Reeves, whom Dr. Lewis had gotten to know quite well. Reeves died in an automobile accident 10 years ago.

Taking his appointment as poet laureate seriously, Dr. Lewis has decided to free his schedule of patients and surgery one day a week and devote it to promoting interest in poetry in the state. "For 24 years, approximately, I have operated five days a week. As of today, it is the first Friday I haven't operated in a long, long time . . . I decided I was going to cut out one day a week surgery and give myself one day that I could talk to school children, and go to places and give talks on poetry and such. I have a lot of Fridays lined up that I can go up to the mountains and talk to school children, give an award at a little library for a grammar school . . . lots of things a poet laureate should do."

Dr. Lewis is the author of one published book of poems, *To Dock at Stars* printed by the University Press in 1962 with a cover design by his artistic wife Christina, an interior decorator. Her design is a dreamy, two-masted sailboat that floats across a starlit sky. A second volume of poems is due for publication soon, called *Small Town* and is reminiscent of *Spoon River Anthology* by Edgar Lee Masters.

"It's written about a small town in Georgia, but it

actually could be any small town anywhere in the country, except for a few poems which are obviously about the South. But most of them are not."

Though Dr. Lewis has appeared in a dozen anthologies of Southern, Southeastern and American poets, he does not consider himself a "regional" poet, and likens his situation to another well-known writer: "I don't mean to compare myself to Robert Frost, but Robert Frost was thought of as a regional poet for a long time. But after a while people realized he was an *American* poet . . . most of his poetry is American, not just from New England, though most of it is about the place he lived."

Remembering the popular poet, Lewis says, "I knew him and was very fond of him, a very attractive fellow. And I loved to hear him read his poetry. He loved to read it and loved to talk about it."

When his first volume was coming out *(To Dock at Stars),* Dr. Lewis took those poems and several others to the Breadloaf Writers Conference in Vermont. Among the critics was John Ciardi, who tends to be "fairly harsh" in his evaluations. "He read

Sun Blush

Perhaps
I should censure
Willie Tufts.
He told me all the story
Just as soon as sober thoughts
Came through the rubble of the night before.

Anna would hardly have been
The last girl on his list
But just as surely
Not the first.
Though she was plump and fair
Her summers numbered
Many more than Willie's did—
And even if her years
Were many less
It's doubtful she could be
Provocative enough
To suit bold Willie Tufts.

For she had been protected
From the cold
Hard facts of life and love
And other dreadful things
Until
She'd never held a hand
Or felt a kiss—
A real kiss—with passion burning through it.
And she was just about beyond
Such things.

But somehow she was there
And Willie too,
And moonlight can play tricks
When least expected,
And "corn" from the county line
Is made to be strong and fast
And, as Willie now knows,
Totally neglected.

I know a few of us
Who must have noticed
Anna blush,
But only I,
Anna
And Will, of course,
Know the story on from there.

Willie worried lest the evening
Might have aftermaths,
And so his doctor
Had to know
For Willie's peace of mind.
But Anna is beyond
Such things
As aftermaths
—or so I thought.

But aftermaths
May come
In varied forms.—

It may be that the noonday sun
Glances off her cheek
At just the angle to expose
Her at her best
On each occasion
That we meet.
I only know
She always seems
To glow.
—And this I know,
She never glowed
Like this before.

Perhaps
I should censure
Willie Tufts.
Somehow
Instead
I drink a toast
To Willie Tufts.

those poems and put some out in brochure form. This whole group of 80 to 100 people criticized it. Their purpose was to tear these poems apart and find out what was wrong with them. So one after another person would get up and express himself. Each time he (Ciardi) would shake his head and say, 'No, that criticism is not valid.' So when everything was down and he hadn't accepted a single criticism, Ciardi said, 'Well, now I'll tell you what is wrong with these poems . . . nothing. He is a good 17th Century poet—not a 20th Century poet.' He thought this was a harsh criticism, but actually it was a high compliment," Lewis feels. "I think of myself as a 17th Century poet, basically." He adds, however, that the poems being evaluated were the more traditional ones of those he writes. His style is quite versatile, "I like to vary it, I like to write different ways" whether it be free verse, lyrics, sonnets or ballads.

Georgia's Literary Community

Meeting with other poets and critics, exchanging ideas and opinions is stimulating to Dr. Lewis, and for years he has been active in the Atlanta Writers' Club, serving as president for a time. He also is active in the Georgia Writers' Association and Dixie Council of Authors and Journalists and knows poets and writers from all over the state. He served as an editor for *Georgia Magazine* 10 years, helping to select material for that publication.

He knows the Georgia literary community and calls it extensive and talented. "Now, whereas we have maybe 50 really good poets in Georgia, we probably have 5,000 who have written a little something once in a while and consider themselves poets. This I mention because whenever a publication has a poetry contest, they are flooded with poems. There are quite a few excellent poets in Georgia and in the South."

In Atlanta he names James Warren and Daniel Whitehead Hickey as writing exceptionally well, and compliments several women: Marel Brown, Florence Hutchings, Jeanne Osborn Gibbs, Julia Evatt and Mrs. Arthur Codington. Savannah, Macon and Augusta have active writing groups, he says, and even his home town of Louisville can boast a second poet, Louise McMillan.

"The South, in general, is a fertile area for writers, not necessarily just for poets," Dr. Lewis says. Georgian Sidney Lanier ranks among his favorite poets right along side Robert Browning.

He feels a writer should take poetry seriously, but not himself seriously. "A poet should never be so sensitive that he doesn't like for people to read his things and offer criticism" for criticism is the best way to learn and improve your skills.

"I have two good friends who think all poetry has to be inspired and make no effort whatsoever to learn anything about poetry. They don't read about it, they don't do anything but sit down and write as the inspiration comes. . . . Their poetry has nice, sweet thoughts, it's overly sentimental. And not good poetry."

He agrees that the good poet is born with an inherent talent for writing. "Most who write have the creative instinct, the creative urge and go from there," but, "I'm a great believer in the fact that genius is 10 per cent mental and 90 per cent hard work."

While soliciting and learning from the criticisms of other craftsmen, Dr. Lewis feels the poet has to develop his own style and sense of confidence to know when a criticism is valid or should be discarded. And he reserves the right to disagree with a critic.

"I sent off this volume *(To Dock at Stars)* to several poets when getting ready to publish. I had each one give me criticism. I ended up taking none of their criticism and making none of the changes, because the changes they suggested were not improving the poems. They were how they would have said these things, and not the way I would have said them. This is my book and I have to say it my way. . . . After it was published they said they liked them and were glad I didn't make the changes," he adds.

Poetry for Children

Dr. Lewis now is working on a volume of "whimsical poetry" for the future which will include a section on a "return to the classics" with take-offs on well known poems. He also is working on a volume of children's verses which will be called *Dragons Are Lonely,* both for and about children.

His own four children provided inspiration: John

The Place of a Gem

The sea is a diamond
Flashing its borrowed fire
Back to the sun and stars,
Buffed of its grime of clouds and fogs and mists
By the cleansing rain
And polishing cloth of winds,—

Cool as the blue of its crystalline depths
And warm as the fire its facets flash,
The sea is a diamond,
Fixed in the setting of the earth,—
One stone in the necklace
Of the universe,
Hanging about the neck
Of God.

This group of patients carries an extremely high mortality rate unless blood pressure control can be maintained.

Renovascular Disease and High Blood Pressure

ALBERT A. CARR, M.D., *Augusta**

UNILATERAL OR BILATERAL occlusive renovascular disease can cause high blood pressure. The mechanism may be activation of the vasoconstrictor renin-angiotensin system or inhibition of a renal vasodilator system such as the prostaglandins. If the blood pressure returns to normal after surgical correction of the occlusive vascular disease, or by nephrectomy, then the diagnosis of renovascular high blood pressure or renovascular hypertension is established. Documentation of occlusive renovascular disease and high blood pressure is not enough evidence for the diagnosis; because, renovascular disease can, and often does, occur in the presence of normal blood pressure. Also, renovascular disease may be associated with another disease process which causes high blood pressure and in this situation surgical correction of the renovascular disease, or nephrectomy, does not result in return of blood pressure to normal. Thus, a method other than response to corrective surgery is needed to establish the diagnosis of renovascular high blood pressure. Such a method would be invaluable to the physician for diagnosis and proper management of patients with renovascular disease and high blood pressure.

This report is about an experience involving 72 patients with a renovascular disease and high blood pressure. Plasma renin activity of peripheral and renal vein blood is evaluated as a method for making an accurate diagnosis of renovascular high blood pressure. Also, the natural history of the disease is documented.

Study Methods

At present, there is an active, on-going, out-patient facility which is following 575 patients with a high blood pressure disease. All the patients in this report were evaluated over the past six years. Renovascular disease was discovered primarily because of: an abdominal bruit, *or* inability to control blood pressure with medications, *or* patient less than 20 years of age with high blood pressure, *or* evidence from an intravenous pyelogram. Many of the patients were referred by other physicians who suspected renovascular disease and wanted further evaluation; thus, the prevalence of renovascular disease in the overall population here is higher than it would be in a non-referral population of patients with high blood pressure.

Renovascular disease was documented in all patients by retrograde femoral renal arteriography. Selective renal artery studies were frequent in order to obtain a better definition of the type of lesion. All arteriographic studies were completed by a radiologist with special training and experience in vascular procedures.

Renovascular lesions are defined according to arteriographic appearance. *Atherosclerotic disease* usually involves the renal artery at, or very near, the aorta. In general there is evidence of atherosclerotic disease of the aorta either above or below the renal arteries. At times when stenosis occurs in the middle of a renal artery with no evidence of aortic disease, it cannot be distinguished from intimal dysplasia. *Fibrous dysplasia* disease is as described by Harrison and McCormack.[1] There are three types: intimal, medial and adventitial. For some of the lesions the arteriographic features are distinctive. For others, microscopic examination of the artery is needed to determine the type of fibrous dysplasia. In general, the appearance between atherosclerotic disease and fibrous dysplasia of a renal artery can be determined by arteriographic appearance. Small aneurysm formation in fibrous dysplasia disease is common and involvement of the aorta does not occur. *Hypoplasia disease* is defined as both a congenitally small renal artery and kidney. *Membraneous* or *fibrous band*s usually occur at the take-off of the renal artery from the aorta. These generally occur in the young patient and there is no evidence of atherosclerosis of the aorta. *Coarctation of the*

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TABLE 1
PLASMA RENIN ACTIVITY NORMAL VALUES

	Position	
	Supine (Range-ng/ml/hour)	Upright
High Sodium Intake		
150-200 mEq/day	0-1.0	0.4-1.1
Low Sodium Intake		
Less than 25 mEq/day	1.4-2.1	2.7-12.5

TABLE 2
TYPES OF RENOVASCULAR DISEASE

		Percentage
Atherosclerotic	(36)	50
Fibrous Dysplasia	(28)	39
Hypoplasia	(3)	4
Coarctation	(2)	3
Other	(3)	4
(Fibrous band or kink in renal artery)		

aorta is demonstrated by physical examination and angiography.

Renin measurements in plasma from peripheral or renal veins were determined after variables other than partial renal artery occlusion, known to change renin secretion, were controlled. Antihypertensives and diuretics were discontinued prior to renin studies. Sodium intake and posture (both upright and supine) were controlled. Renin measurements were made after most of the patients had been on a sodium intake of 150-250 mEq per day for five to seven days and had been in the supine position from eight to 14 hours. Renin activity was measured by bioassay[2] until 1971; since then, a radioimmunoassay has been used.[3] Normal values for peripheral vein plasma renin by radioimmunoassay have been established for these studies. The studies involved 75 subjects without high blood pressure, renal disease, liver disease or heart disease. These subjects were considered normal and on no medications. Renin measurements were made on varying sodium intakes and in both supine and upright posture. Sodium intake was determined by the amount of sodium in a 24 hour urine collection the day blood was collected for renin measurement. Normal values are shown in Table 1.

All the patients with renovascular disease were divided into groups according to severity; severe, moderately severe and mild. The definitions of these groups are: **Severe**—1) initial diastolic blood pressure of 90-130 mm of Hg with any of the following; heart failure, renal failure, cerebrovascular accident, transient ischemic attack, retinal linear hemorrhages or retinal cotton wool spots (exudates), 2) initial diastolic blood pressure greater than 130 mm of Hg, 3) diastolic blood pressure of 105 mm of Hg, or greater, on maximum antihypertensive medications and 4) poor pill taker. **Moderately Severe**—1) initial diastolic blood pressure of 90-130 mm of Hg with; left ventricular enlargement, past myocardial infarction, angina pectoris and diastolic blood pressure controlled to less than 105 mm of Hg, 2) initial diastolic blood pressure of 90-130 mm of Hg without left ventricular enlargement, past myocardial infarction, angina pectoris and diastolic blood pressure controlled to less than 105 mm of Hg but not less than 95 mm of Hg and 3) initial diastolic blood pressure of 90-130 mm of Hg with or without left ventricular enlargement, past myocardial infarction or angina pectoris and taking three or more antihypertensives for control of diastolic blood pressure of less than 105 mm of Hg. **Mild**—1) initial diastolic blood pressure of 90-130 mm of Hg with no left ventricular enlargement, heart failure, angina pectoris, past myocardial infarction, renal failure, cerebrovascular accident or transient ischemic attack and 2) diastolic blood pressure controlled to less than 95 mm of Hg with not more than two antihypertensive medications.

Blood pressures used for the data in this report were sitting, casual measurements. Three measurements were made and the average of the last two used for the final figure. The findings of these patients with renovascular disease are compared with those in the overall patient population a high blood pressure disease (general high blood pressure) followed in our on-going, out-patient facility.[4, 5]

Results

Renovascular lesions were demonstrated in all patients by renal arteriography. There were three major complications from the procedure, two of which were severe bleeding from the femoral artery puncture site and one being hypotension and clinical shock, occurring three hours after completion of the study. Fever for a few hours after arteriography is common and was considered only a minor complication.

Atherosclerotic lesions were responsible for 50 per cent of the renovascular lesions demonstrated. The next most common lesion was fibrous dysplasia, accounting for 39 per cent. The types of renovascular diseases are shown in Table 2. A congenital fibrous or membraneous band at the origin of the renal artery and an abnormal kink in the renal artery was present in 4 per cent of the patients.

When the patients with renovascular disease and high blood pressure are compared to our overall group of patients with a high blood pressure disease, there are apparent differences. The patients with fibrous dysplasia disease are predominately white and female; those with atherosclerotic disease are

predominately white and male. The entire renovascular disease group is predominately white and male and our overall high blood pressure group is predominately black and female as shown in Table 3. There was not one black male with atherosclerotic renovascular disease.

Table 4 shows associated findings with the renovascular disease-fibrous dysplasia and atherosclerotic disease. Aneurysms of the renal arteries are common in fibrous dysplasia. Also, 35.7 per cent of these patients with fibrous dysplasia had bilateral disease. In contrast, there were no renal artery aneurysms in the atherosclerotic disease group, but 11 per cent had an aneurysm of the abdominal aorta. There was evidence of bilateral renal artery involvement in 16.7 per cent of the patients with atherosclerotic disease. The associated finding of pheochromocytoma, *or* neurofibromatosis *or* Cushing's disease in 13 per cent of the patients with fibrous dysplasia is striking and warrants comment, later.

Endarterectomy, renal artery bypass and nephrectomy were the surgical procedures used for correction of renovascular abnormalities. There were no operative deaths nor deaths in the immediate post-operative period. Nephrectomy was necessary in three patients, although bypass was attempted and considered possible prior to the operation. Two of the patients had congenital membranous or fibrous bands at the origin of the renal artery and one had fibrous dysplasia. A large aortic aneurysm was found in two patients unexpectedly at surgery as there was no evidence of this at physical examination or aortography. One was too extensive to repair and the other was corrected. One patient suffered a cerebrovascular accident in the post-operative period and another, an acute myocardial infarction after an upper gastrointestinal hemorrhage from a duodenal ulcer. Splenectomy was necessary in one patient because of bleeding from an accidental rupture at surgery. Deep vein thrombophlebitis occurred in another patient but no pulmonary embolus. All of these patients had atherosclerotic renovascular disease but recovered and are now doing well.

Summarized in Table 5 are the age ranges of the patients according to the type of renovascular disease and whether or not surgery completed. The age range is much younger for those patients with fibrous dysplasia. Those with atherosclerotic disease are similar in age to the overall high blood pressure population. The patients who had surgery were generally younger than those who did not have surgery.

The severity of the high blood pressure disease was greater in the patients with renovascular disease as compared to the overall high blood pressure group as summarized in Table 6. Severity of disease was greater in those chosen for surgery and most severe in those with atherosclerotic renovascular disease

TABLE 3

COMPARISON OF RENOVASCULAR DISEASE GROUP TO OVERALL HBP GROUP

	Renovascular Disease			
	All	Fibrous Dysplasia	Atherosclerotic	Overall HBP
Race — Sex	%	%	%	%
White—Male ..	46	15	70	8
Black—Male ..	7	15	0	28
Black—Female	12	19	8	60
White—Female	35	51	22	4

TABLE 4

ASSOCIATED FINDINGS

	Fibrous Dysplasia %	Atherosclerotic %
Aneurysm of Aorta	0	11
Aneurysm of Renal Arteries	14	0
Pheochromocytoma	7	0
Neurofibromatosis	3.5	0
Cushing's Disease	3.5	0
Bilateral Disease	35.7	16.7

TABLE 5

RENOVASCULAR

Age (Years)	Fibrous Dysplasia	Atherosclerotic	Surgery	No Surgery	Overall HBP
1-19	4	0	9	0	1.6
20-29	27	0	12	16	6.6
30-39	39	11	25	18	17.5
40-49	23	35	31	29	28.3
50-59	7	30	13	21	31.0
60-Greater	0	24	9	16	15.0

TABLE 6

SEVERITY OF DISEASE

	Severe %	Moderately Severe %	Mild %
Overall HBP	37	32	31
Renovascular			
No Surgery	49	23	28
Surgery	52	26	22
Fibrous Dysplasia			
No Surgery	40	33	27
Surgery	46	54	0
Atherosclerotic			
No Surgery	57	17	26
Surgery	69	8	23

who had surgery. The reasons patients did not have surgery were: 1) lesion not optimal for surgical repair and/or bilateral involvement, 2) severe aortic disease, 3) severe renal failure, 4) poor overall clinical status and 5) patient's refusal to undergo surgery.

High blood pressure is considered corrected by surgery only if the diastolic blood pressure returns to 90 mm of Hg, or less, on no anti-hypertensives or diuretics. Using this criteria, 71 per cent of all the patients having surgical correction were cured of their high blood pressure as is shown in Table 7. The chances of blood pressure returning to normal were slightly better after nephrectomy as compared to repair of the renal artery or bypass. When the renal vein renin ratio between affected and contralateral (or less severely affected) side was two or greater, the blood pressure returned to normal in 75 per cent of those patients treated by surgery. However, when ratio of 1.5 or greater was used, blood pressure returned to normal in 70 per cent. When the ratio was less than 1.5, blood pressure returned to normal in 50 per cent and remained high in 50 per cent. When peripheral plasma renin was high, blood pressure returned to normal in 90 per cent of those patients after surgery. When the peripheral plasma renin was normal or low, blood pressure did not return to normal in 87.5 per cent of the patients after surgery.

Length of follow-up on the patients is important. Table 8 shows the length of time involved with follow-up, which is similar for patients after surgery and after no surgery.

Mortality is clearly less in the group after surgery; in fact, 4.6 times less than the group with no surgery as shown in Table 9. The striking feature is a mortality of 28.9 per cent in patients who did not have corrective surgery. The mortality for these was 7.8 times greater than the overall high blood pressure group. There have been only two deaths in the patients treated by surgery. One, a male of 72 years of age who had atherosclerotic disease, minimal renal failure and heart failure. He was cured of his high blood pressure but died suddenly. The other, a young lady 24 years old who had fibrous dysplasia. Her high blood pressure was not corrected by surgery and she died of malignant hypertension.

As would be expected, the age of death in the group of patients with fibrous dysplasia was younger than the atherosclerotic group. Table 10 depicts the age ranges. As shown in Table 11, those who died had the most severe disease. It is of interest that of those who died, 30 per cent did not have high peripheral plasma renin. As shown in Table 12, those who did not have surgery and died had renal or heart failure to a greater degree than the overall high blood pressure group. The peripheral vein renin was elevated in 100 per cent of the patients who died and in whom the blood pressure could not be

TABLE 7
RESPONSE TO SURGERY

	Percentage Correction of High Blood Pressure
Overall (31)	71
Nephrectomy	73
Repair of Renal Artery or Bypass	63
Renal Vein Renin Ratio > 2.0	75
Elevated Peripheral Plasma Renin Activity	90

TABLE 8
YEARS FOLLOW-UP

	Surgery %	No Surgery %
Less than 1 Year	19	19
1-2 Years	29	32
3-4 Years	29	22
5-6 Years	23	27

TABLE 9
MORTALITY

	Percentage	Ratio to Overall HBP
Overall HBP Group	3.7	
Renovascular		
No Surgery	28.9	7.8
Surgery	6.3	1.7

TABLE 10
AGE OF THOSE WHO DIED

Age (Years)	Fibrous Dysplasia %	Athero-sclerotic %	Overall HBP %
20-29	25	0	5
30-39	25	11	5
40-49	25	11	47
50-59	25	22	11
60-Greater	0	56	32

TABLE 11
SEVERITY OF THOSE WHO DIED

	Surgery %	No Surgery %	Overall HBP %
Severe	100	82	94
Moderately Severe	0	9	6
Mild	0	9	0

controlled by medication. In those patients whose blood pressure was controlled with medication, but died anyway, the peripheral plasma renin was normal or low in 66 per cent. The peripheral vein plasma renin was normal or low in 82.6 per cent of the patients who did not have corrective surgery and whose blood pressure was controlled by medications. In contrast, it was elevated in 88 per cent of those whose blood pressure was not controlled.

Finally, in Table 13 the type of renovascular disease and whether or not corrective surgery was attempted is correlated with mortality. The highest mortality is in the atherosclerotic group and having no surgery. It is of interest, those with atherosclerotic renovascular disease who did not have surgery showed 40 per cent mortality when the peripheral vein plasma renin was high and 23 per cent mortality with normal peripheral vein plasma renin.

Discussion

When renovascular disease is present with high blood pressure, the overall disease process is severe. Mortality is extremely high when corrective surgery is not performed. This is especially true of those with atherosclerotic renovascular disease and elevated peripheral vein plasma renin activity. Also, blood pressure was not controlled well with medications in the high peripheral vein plasma renin group.

This data indicates if it is at all possible, corrective surgery should be attempted in those patients with elevated peripheral vein plasma renin activity and renovascular disease. Mortality is extremely high if surgical correction is not completed. An elevated

TABLE 12

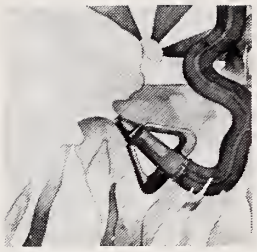
MORTALITY
(Other Findings)

Type of Disease	Renovascular Surgery %	Renovascular No Surgery %	Overall HBP %
Renal Failure	100	45	31
Heart Failure	50	55	21
CVA	50	36	32
High Renin	100	70	Unknown

TABLE 13

MORTALITY

Type of Disease	Mortality %
Fibrous Dysplasia—Overall	14
Fibrous Dysplasia—No Surgery	18
Fibrous Dysplasia—Surgery	9
Atherosclerotic—Overall	25
Atherosclerotic—No Surgery	33
Atherosclerotic—Surgery	8



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Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Medical Department, Box 5110, Chicago, Ill. 60680 481

peripheral renin value predicts well the restoration of blood pressure to normal after surgery. Renal vein renin ratios give both false positive and negative results in terms of predicting cure by surgery. This may be due to labelling problems or a problem with getting actual renal vein collections. When bilateral disease is present, renal vein renin values can be of help in determining which side should be corrected first. Caution is needed for interpretation of renin values. There are many variables which can alter renin secretion. These are: sodium intake, posture, diuretics and antihypertensive drugs. These may be the reasons other studies have shown better correlation of surgical results to renal vein renin measurement as compared to that of peripheral vein plasma, since antihypertensives were not discontinued prior to study.[6] In addition, normal value must be well established for the laboratory and extreme care used in the actual determination. High quality laboratory methodology is essential. When the above are considered and peripheral vein plasma renin activity is low or normal, it is highly unlikely that surgery will result in blood pressure returning to normal.

The unexpected finding of aortic aneurysms makes it mandatory for the surgeons involved to be skilled and experienced in vascular surgery, which includes work with abdominal aortic aneurysms.

It is of interest that renovascular high blood pressure is a disease of the white population and is rare in blacks. When it does occur it is mostly fibrous dysplasia in the black population.

The finding of pheochromocytoma, in association especially with fibrous dysplasia disease, is important. Neurofibromatosis is associated with vascular lesions which look like fibrous dysplasia on arteriography but are slightly different in terms of histology.[7] Thus, patients with high blood pressure and neurofibromatosis, or cafe au lait spots, should be considered candidates for a renovascular high blood pressure disease.

As result of this experience certain clinical findings should make the clinician consider a renovascular high blood pressure disease. These are: 1) high blood pressure which cannot be controlled to less than 105 mm of Hg diastolic pressure with optimal medications and especially those with high peripheral vein plasma renin activity, 2) high blood pressure associated with an abdominal bruit, 3) recent onset, between one and two years, of *severe* high blood pressure in a patient over age 40 years, 4) high blood pressure in a patient younger than 20 years old, 5) high blood pressure associated with cafe au lait spots, *or* neurofibromatosis, *or* pheochromocytoma, and 6) high blood pressure associated with high peripheral vein plasma renin activity, especially during high sodium intake in supine position and on no medications. In general, suspician should be less in the black population, especially in the black male. Patients over 50 years of age are, in general, less optimal candidates for surgery. With older age generalized vascular disease is more likely. This probably reduces the chances for cure somewhat; and also, may result in higher post-operative morbidity and mortality. However, the extremely high mortality of a renovascular high blood pressure disease warrants strong consideration for surgery even in the older age category, especially if the blood pressure cannot be controlled and if peripheral vein plasma renin is elevated. Renal excretory failure generally means the chances of success with surgery are poor. Usually when the serum creatinine is 2.0 mg per cent or more, patients are not considered candidates for surgery. There is no good evidence to support the view that correction of partial or complete renal artery occlusion improves renal excretory function. Again, if the blood pressure cannot be controlled with medications, then the possibility of a renovascular disease and surgery should be considered. This is especially true if the peripheral vein plasma renin activity is elevated.

Summary

An experience with 72 patients with high blood pressure and renovascular disease is given. The mortality rate is extremely high in this group of patients unless blood pressure control can be maintained. Surgical correction of the renovascular disease has a beneficial effect and results in a remarkably reduced mortality rate and restoration of blood pressure to normal. The peripheral vein plasma renin activity measurements, if done carefully, are of predictive value. ■

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Gov. Busbee reports on his first one hundred days in office to guests at the GaMPAC Brunch.

Accomplishments and Goals of the Governor's Office

GOVERNOR GEORGE D. BUSBEE, *Atlanta**

I AM HONORED to be asked to address this gathering of the Georgia Medical Political Action Committee. I spoke to many of you last year in Savannah shortly after I had announced my candidacy, and because Dan Bateman and Jim Kaufmann said I had "a little" more credibility this year they encouraged me to address you this morning.

Today I would like to report to you on my first hundred days in office. I have worked on a budget, been through a legislative session, and I am basically pleased with our productiveness. We made progress in giving the taxpayers some relief, we added a kindergarten program, made quality improvements in several areas of education, funded a bond issue for early completion of I-16 and I-185, and launched expansion and improvement programs for several ports. I believe our priorities were right, our direction positive, but we must always strive to improve the services of government.

We still have some weak areas. A couple of these areas are of particular interest to you as members of the medical profession, and I would like to briefly discuss them with you.

Streamlining the DHR

As Governor, I inherited a wealth of problems in the form of the Department of Human Resources. But the General Assembly gave me the go-ahead to cut out some of the excess, to pare some of the nonessential levels of management and restructure the Department so that it can more effectively serve the human needs entrusted to it. As DHR now exists there is overlapping authority, clouded lines of responsibility, warring factions, and generally, low morale.

In many ways we are hampered by federal guidelines in the programs DHR administers. But we will not sit back in frustration . . . we are tackling the problems, trying to define the areas in which we can affect change, and we will make improvements.

We are going to launch Project Streamline to correct and restructure DHR. Members of my staff are interviewing members of the Department and analyzing the facts. So we are beginning to isolate distinct problem areas for more concentrated study. I personally will be directing Project Streamline and will visit many DHR facilities throughout the state to gain first hand knowledge of the operation. Shortly, I anticipate that I will have an announcement on the new commissioner.

Medicaid Payments

Perhaps another area of interest to you is the suspension of Medicaid payments for optometry and dental care. I was forced to temporarily shut down these programs because of abuses, over-utilization and misutilization. My purpose is simply to "get a handle" on the programs.

I want to make it clear at this point that whatever abuses we uncover will represent the actions of but a fraction of the good, dedicated dental and optometric practitioners in Georgia. Their professional associations have cooperated with me completely in forming peer review committees and in ferreting out the abuses.

Malpractice Insurance

I know an issue that is of utmost concern to every physician in Georgia and the United States is that of your professional liability or malpractice insurance.

This is of growing concern not only to you in the amount of premiums you pay and the amount of coverage you get, but also to all Georgians, for they will eventually share this additional expense. And if this problem does continue to grow and physicians are forced to curtail their practices, then the citizens of Georgia will lose the excellent medical care now available to them.

* Delivered at the brunch meeting of the Georgia Medical Political Action Committee, Saturday, April 19, 1975, at the Fairmont Colony Square Hotel during the 1975 Annual Session Business Meeting of MAG.

I am informed that Georgia has one of the eighth lowest professional liability rates in the U. S. today. However, the trend across the country and the problem our adjacent states are facing today proves to me that steps need to be taken *now* that will insure me . . . you . . . and all Georgians . . . that this extreme others are facing will *never* be experienced in Georgia. To do this I want to announce at this time my future plans to appoint a study commission to study this problem.

My plans are to appoint to the study commission . . . members of the Medical Association of Georgia, members of the Georgia Bar Association, members of the Georgia Hospital Association, representatives of the insurance industry and representatives of the public sector. This commission will then make recommendations to me to help solve this problem by legislative implementation or, if need be, by executive order.

Health Service Areas

An additional area which is vitally concerning me and consuming the time of many of my staff members and should be of special interest to doctors . . . is the health services area.

We in Georgia are required by the new National Health Planning and Resources Development Act of 1974 to divide our state into designated health service areas by a May 3 deadline.

This requirement was contained in Amendments to the Public Health Service Act recently enacted by Congress . . . and I foresee that the changes are leading to tighter planning for health service needs and stricter controls over federal expenditures for health services.

The new federal legislation combines several federal grant programs under a single umbrella and establishes new mechanisms for certifying needs for future federal planning.

The programs being merged are the Hill-Burton Program for hospital construction, the Regional Medical Program and Comprehensive Health Planning Program.

Since the designation of the health planning area is such an important undertaking . . . I have worked to establish the most equitable possible methods for making the decisions . . . allowing those concerned with health planning at all levels as much input as possible in working out the best health areas for our state.

I have appointed the Director of the Office of Planning and Budget, Jim McIntyre, to be in charge of the process of gathering information about health service patterns throughout the state.

We dispatched 250 letters to health associations, mayors, county commissioners, providers of health services, including the Medical Association of Georgia and consumers of health services . . . to solicit their views on the designation of health planning areas.

Jim McIntyre worked with a 28 member advisory council in digesting the opinions into five alternative plans for the health areas.

We are asking the public for comments on the alternatives in a series of six public hearings in Georgia's major cities. A hearing in Savannah was completed yesterday. There will be hearings in Columbus, Albany, Macon, Atlanta and Augusta next week.

We are working very hard to meet the May 3 deadline on this requirement and needless to say we are making every effort to discover the opinions of all who are affected by this major undertaking.

Once health service areas have been designated the next step is development of health systems agencies for the funneling of federal funds.

This morning I have tried to give you an overview of what we have done in my administration and also an idea of the hurdles we have yet to cross. We seek dialogue, not monologue in discussing and meeting the challenges of state government. I solicit your advice both as doctors and as concerned citizens.

Thank You. ■

REMINDER TO RETURN DHR QUESTIONNAIRE ON PHYSICIANS' LABORATORIES

Questionnaires have been mailed by the Department of Human Resources to half the membership of the Medical Association of Georgia. The purpose of the questionnaire is to determine what laboratory work is being done in physicians' offices, what personnel perform the laboratory work, and what proficiency testing is used. Those who received the one-page questionnaire were requested to return it by July 15. Those who have failed to meet the deadline are urged to get the questionnaires in as soon as possible.

editorials
editorials
editorials

Whole-Hearted Endorsement

THE CHEC PROGRAM, described in the cover article, may well be one of the most important programs that organized medicine has implemented in Georgia. It is certainly the most visible.

CHEC represents an effort—a very high priority effort—by the Medical Association of Georgia and the Georgia Medical Care Foundation to retain physician authority for decision-making as to medical necessity and appropriateness. Such decisions are most effectively and most properly made by practicing physicians, not by fiscal intermediaries, insurance companies, or state or federal employees (be they physician or non-physician). CHEC further emphasizes that review—concurrent review in particular—must be performed by those practicing physicians most aware of the cricumstances surrounding each case—the physicians on the medical staff of the local hospital.

Organized medicine in Georgia has successfully secured the commitment of the Georgia Hospital Association, the Blue Cross Plans, and the private insurance carriers to the operation of a single concurrent review program in Georgia hospitals—the CHEC program of the Georgia Medical Care Foundation. CHEC is implemented for Medicaid on August 1. Other review programs should be replaced by CHEC in the coming months.

The House of Delegates of the Medical Association of Georgia has given its "whole-hearted endorsement to the implementation of CHEC for the Medicaid Program on a state-wide basis as soon as possible and for other government and private programs when similar funding is made available by them." The CHEC program requires your whole-hearted endorsement as well—and your active support.

Earnest C. Atkins, M.D.
President, Georgia Medical
Care Foundation
2910 N. Druid Hills Road
Atlanta, Georgia 30329

Letter to the Editor

Dear Sir:

Even though there is no department in the *Journal* for letters to the editor, some reference should be made in the *Journal* concerning the article on snake bite treatment by Mr. and Dr. Bryant (April issue).

Physicians who are rarely confronted by this emergency tend to follow written advice (taken from books, journals, the insert with the anti-venin, etc.) and if they inadvertently adhere to the steps in this particular article, I believe any reviewer who is familiar with the problem would agree that the advice is not particularly proper.

Without a long letter, the questionable advice is in step number two in which the authors advise the physician to make no attempt to evaluate individual bites and further advise the physicians to assume all bites to be fatal. There is not universal agreement, of course, in all subsequent steps suggested, but the genuinely mischievous part is step number two.

H. B. Bechtel, M.D.
2101 N. Patterson Street
Valdosta, Georgia 31601

president's letter



Avoiding a Malpractice Crisis

I AM SURE BY NOW everyone has received the information on the Professional Liability Insurance policy changes from "occurrence" to "claims made" and the premium changes. Bill Moore and his committee are to be commended for the outstanding work they have done for the MAG over the years. We cannot heave the usual sigh of relief and say "that's done for another year." We are fortunate that we have a year in which to avoid the "malpractice crisis" that has plagued our colleagues in other states.

Bill Moore and I with staff members L. B. Storey and Rusty Kidd met with Mr. Johnny Caldwell, Insurance Commissioner of the State of Georgia and representatives of the Georgia Bar Association, Georgia Hospital Association and representatives of Mr. Caldwell, one of whom was our own Tom Sappington. Mr. Caldwell called this meeting to "get you people together to talk about medical liability insurance." We did just that. The discussion was informal and frank. The very encouraging fact was the feeling of cooperation among all participants. We are to meet again at a later date after the various staffs have worked on details.

Governor Busbee announced at the GaMPAC breakfast at the Annual Session, that he was going to appoint a medical malpractice study commission composed of representatives of MAG, Georgia Hospital Association, Georgia Bar Association, state government, insurance industry and the public. This is in the process of being done.

I feel that we have the opportunity to solve most of the malpractice problems before they become acute.



David A. Wells, M.D.
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David A. Wells, M.D.
President, Medical Association of Georgia

heart page
heart page
heart page

Current Status of Prosthetic Valve Replacement

JOSEPH I. MILLER, M.D. *and* JOSEPH M. CRAVER, M.D., *Atlanta**

THE MODERN ERA OF CARDIAC value replacement began in 1960 when Harken, Starr, and their colleagues successfully replaced diseased aortic and mitral valves with ball valve prostheses.[1, 2] Progress in valve design and construction and increased understanding of intraoperative myocardial preservation have combined to reduce morbidity and mortality from valve replacement to less than 5 per cent. The present discussion will concern current indications for cardiac valve replacement and the type prosthetic valves currently preferred.

A. Indications for Study and Valve Surgery. A study of the natural history of aortic and mitral valve disease has enabled a number of significant conclusions as well as indications for valve replacement to be made. In general, chronic stenotic lesions of either valve appear to have a poorer prognosis than chronic regurgitant lesions when left alone and usually warrant surgical intervention at an earlier functional stage of the disease.[3] However, insufficiency of either valve produced acutely is poorly tolerated and may constitute a surgical emergency.

Mitral Stenosis: Mitral stenosis is well tolerated in the average patient, and he frequently remains asymptomatic for approximately 10-15 years after the initial diagnosis has been made. Once peripheral emboli occur or when the patient becomes symptomatic with daily activity, progression of the disease is usually rapid. These patients need cardiac catheterization and evaluation for corrective surgery. The difficult decision for surgical intervention generally occurs in patients whose symptoms occur only on mild exertion. The degree of disability and the particular circumstances of that patient must be individually weighed in reaching a decision regarding surgery.

Mitral Insufficiency: Acute mitral insufficiency due to rupture of chordae tendonae or the papillary muscle may constitute a surgical emergency as profound cardiac failure may result in 12-24 hours. Chronic mitral insufficiency is often well tolerated for many years before the onset of symptoms. Once these patients become symptomatic on daily activity, we recommend that cardiac catheterization be undertaken and mitral valve replacement considered.

Aortic Insufficiency: In a patient with acute aortic insufficiency and a small, noncompliant left ventricle, medical therapy is frequently associated with a high rate of mortality, often within hours to days.[3] Patients with traumatic lesions or acute endocarditis producing massive aortic insufficiency should be considered as candidates for emergency aortic valve replacement. Patients with chronic aortic insufficiency often do well for many years without any disability. Once the onset of symptoms of congestive heart failure have become established, the majority of patients die within two years or respond poorly following valve replacement.[3]

* Carlyle Fraser Heart Center, Crawford W. Long Memorial Hospital, 25 Prescott St., N.E., Atlanta, Ga. 30308. Each physician serves as an assistant professor of thoracic and cardiovascular surgery for Emory University School of Medicine. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

Thus, asymptomatic patients with aortic insufficiency who demonstrate cardiomegaly or increasing left ventricular hypertrophy by electrocardiogram despite medical management should be considered for elective valve replacement.

Aortic Stenosis: The majority of older patients with isolated aortic valve stenosis have congenitally bicuspid aortic valves and remain asymptomatic for a period of years. Once the symptoms of congestive heart failure, angina pectoris, or syncope develop, the mortality is approximately 50 per cent in a two-year period, and the incidence of sudden death is quite high.[3] The patient with aortic stenosis compensates for the degree of obstruction by hypertrophy of the left ventricle. Our experience has indicated that once the symptomatic patient develops significant left ventricular hypertrophy as manifested by electrocardiogram or chest roentgenogram and has, at catheterization, a valvular gradient greater than 75 mm Hg, the possibility of reversing the lesion may not be present. We feel that any patient with significant left ventricular hypertrophy by electrocardiogram or chest roentgenogram with a systolic aortic gradient greater than 75 mm Hg, even though he is asymptomatic, should be operated on as an elective procedure. Once the patient develops the symptoms of congestive heart failure, angina, or syncope, he should be operated on as a semi-emergency as the prognosis without correction is extremely poor.

We have briefly outlined our indications for cardiac valve replacement at the present time. Many questions remain unanswered. For example: "Do asymptomatic patients or those with minimal symptoms have anything to gain from valve replacement? Does ventricular function stay the same, improve, or deteriorate, and can these results be reliably predicted preoperatively? Can left ventricular performance be preserved by earlier operation?"[4] These answers are becoming available as reduced operative mortality is encouraging referral of more people in the early stages of cardiac disease for valvular correction.

B. Prosthetic Valves. In designing a valve prosthesis there are a number of important factors which should be considered. These are: durability, hemodynamic characteristics, thromboembolism rates, assurance of function, availability, ease of insertion, and record of survival.[4] The two most widely used prosthetic cardiac valves at present are the tilting disc prosthesis (Björk-Shiley) and the mounted heterograft valve (Hancock).

The Björk-Shiley valve is a low profile, tilting disc valve that was introduced in 1969. It has titanium struts with a teflon sewing ring and pyrolite carbon disc. Its advantages are: 1) the low incidence of thromboembolism; 2) central laminar flow secondary to the use of the tilting disc, thus greatly decreasing hemolysis; 3) improved hemodynamics, the largest orifice to tissue diameter ratio of any valve with the smallest gradient across the valve even with exercise; and 4) ease of implantation particularly in the small aortic root.[5] We anticoagulate all patients with sodium warfarin (Coumadin) beginning on the fourth postoperative day when this prosthesis has been employed. A recent study of 456 patients undergoing isolated mitral or aortic valve replacement with this prosthesis reported the following figures.[6] In mitral valve replacement, there was a 3.5 per cent incidence of early death and a 4.7 per cent incidence of late death. There was a 3.9 per cent incidence of postoperative thromboembolism. In the group undergoing aortic valve replacement, there was a 13 per cent incidence of early death and an 8 per cent incidence of late death. There was a 0.9 per cent incidence of thromboembolism. In the overall study, there was a 2.7 per cent incidence of thromboembolism. Ninety-five per cent of the survivors were significantly improved after surgery. Two per cent were unchanged, and 3 per cent were worse. We feel that a particular indication for the Björk-Shiley valve is in those patients who have an extremely small aortic root where the advantages of the tilting disc improves hemodynamics over all other currently available prostheses.

The other valve which we employ and have used for the past 15 months is a Hancock tissue heterograft valve which consists of a porcine aortic valve mounted onto a dacron covered flexible stent and sewing ring. The gluteraldehyde process

eliminates the tissue antigenicity and thereby prevents immunologic rejection while also preventing collagen denaturation. The predominant advantages are as follows: 1) the lack of thromboembolism; 2) the avoidance of chronic anticoagulation; 3) central free-flowing dynamics; and 4) the low gradients across the valve even with exercise. The main uncertainty is the long-term durability of the tissue valves. Two studies of approximately 1500 implanted Hancock valves revealed 2.3 per cent late deaths and 5 per cent early deaths.[7, 8] The following complications were noted: 1) emboli, 1.7 per cent with only one death; 2) cusp perforation, 0.3 per cent; 3) subacute bacterial endocarditis, 0.15 per cent; and 4) functional stenosis, 0.15 per cent. Perivalvular leak occurred in eight patients, and no patients had significant valve dysfunction. Particular indications for this valve are those patients in whom postoperative anticoagulation is contraindicated and in children or young adults.

In summary, any patient with valvular heart disease should be considered as a potential candidate for operative correction. An operative mortality of less than 5 per cent should be obtained and excellent functional results achieved. The new type of prosthetic valves now available appear to reduce further the incidence of thromboembolism and late complications and to improve both the quality and longevity of patient life. ■

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ATLANTA IS SITE OF SEPTEMBER HEART SESSIONS

The Georgia Heart Association's 27th Annual Meeting and Scientific Sessions will be Friday through Sunday, Sept. 12-14, at the Royal Coach Motor Hotel in Atlanta.

The annual meeting for members and volunteers will be Friday, climaxed by a luncheon at which Robert G. Ellison, M.D., of Augusta, president of GHA, will review the accomplishments of 1975 and tell what lies ahead for the Georgia Heart Association in 1976.

In addition to Scientific Sessions for Physicians and Scientific Sessions for Nurses, GHA will offer a new session this year for dietitians and nutritionists.

Faculty for the Scientific Sessions for Physicians will include these featured speakers: Agustin Castellanos, Jr., M.D., University of Miami School of Medicine, Miami, Fla.; Glenn M. Friedman, M.D., F.A.A.P., Papago Buttes Pediatric Center, Scottsdale, Ariz.; Taher El Gammal, M.D., Medical College of Georgia, Augusta; Julien I. E. Hoffman, M.D., F.R.C.P., University of California School of Medicine, Cardiovascular Research Institute, San Francisco, Calif.; Herbert R. Karp, M.D., Emory University School of Medicine; and Charles Rob, M.D., Chairman, University of Rochester School of Medicine and Dentistry, Rochester, N. Y.

Topics for discussion at the physician's sessions will include cerebral vascular disease, cardiac pacemakers and congenital and acquired heart disease. A portion of the program will be devoted to Cardiology Problem Solving, with six physicians presenting the case histories of patients with common problems in adult and pediatric cardiology.

For more information, contact the Georgia Heart Association, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

Due Process Requirements for "Private" Hospitals and Professional Societies

JAMIE HINGLE ROCK, *Atlanta**

In April, the Legal Page carried an article concerning hospital staff privileges for podiatrists. The article stated that a private hospital can pretty much admit or deny staff privileges as its board of directors and staff see fit, so long as the denial was not based on race, sex, religion, or national origin. A public hospital, however, must provide that staff privilege determinations are consistent with the mandates of the United States Constitution regarding due process and equal protection.

This public/private distinction arises because of the language of the 14th Amendment to the Constitution: "No State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." This language has been interpreted as requiring a finding of "state action" before the question of denial of due process or equal protection can be considered. (There is also a requirement of state action in the proposed Equal Rights Amendment.) The criteria for determining whether or not state action is present are not written on stone, and the concept has been extended far beyond the boundaries probably anticipated by the drafters of the Fourteenth Amendment.

Two recent lines of lawsuits expand the grounds upon which private actions may be subject to scrutiny as if they were public actions, one set dealing with "private" hospitals and staff privileges and the other set dealing with professional societies. It is these lines of cases that will be discussed this month.

Lawsuits Dealing With Private Hospitals

1. Acceptance of Hill-Burton construction funds and the resultant state regulation of use of these funds were not sufficient "ties" to make the actions of a private hospital subject to review as state actions until 1963.[1] In that year, the U. S. Court of Appeals for the Fourth Circuit (the Fourth Circuit consists of the states of Maryland, Virginia, West Virginia, North Carolina and South Carolina) held that the receipt of these funds and the state regulation thus entailed required the Moses H. Cone Memorial Hospital in Greensboro, North Carolina, to obey the equal protection mandate in the Fourteenth Amendment.[2] The Court also held the "separate but equal" provision of the Hill-Burton Act unconstitutional. Though this case has not been affirmed by the United States Supreme Court, the view expressed has been widely accepted. The case was concerned only with a question of racial discrimination. It has been noted by many commentators, and sometimes by the courts themselves, that the courts are more willing to find state action when

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* Prepared at the request of The Medical Association of Georgia. Ms. Rock is a summer associate in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association. Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303. Ms. Rock is a medical technologist (ASCP) having received her B.S. degree from Louisiana State University. She has completed her second year at Duke University Law School.

the claim involves a charge of racial discrimination rather than a denial of due process. This distinction has been applied by several courts in cases involving due process requirements and staff privileges, and the courts have held that there was not state action.

Now, however, the Fourth Circuit Court of Appeals has held that an otherwise private hospital which receives Hill-Burton funds must afford both substantive and procedural due process to doctors who are suspended from the hospital staff or who are seeking admittance to the hospital staff.[3] This view has not as yet been accepted by the other Circuits,[4] and a recent case in the federal court for the Northern District of Illinois reviewed all the decisions dealing with Hill-Burton funds and due process, finding that there was no state action in such a situation.[5] It does, however, appear to be the trend in California[6] (which is often taken to show the shape of things to come in the law). Under this view, a doctor on the board of directors or staff of a "private" hospital which has received public funds may find his actions as to staff privileges subject to the scrutiny of the courts. If the holding in this case is followed, such hospitals may have to revise their procedures and criteria to remain on the safe side and avoid lawsuits. This is not to say that the courts will establish criteria for admittance to a staff, but only that the criteria which are applied must be reasonably related to the standard of care and operation of the hospital and must not be applied in a discriminatory manner. There must be a fair hearing where the applicant can confront witnesses against him, and he must be advised of the reasons he is being suspended or his application denied. For example, a board or staff would not be able to deny privileges to a doctor simply because they didn't like him or hold a closed meeting and then just deny the application without giving any reasons for doing so.

Decisions Concerning Professional Organizations

2. The Supreme Court of the State of California has held that a professional organization which controls board certification of a group (i.e., the Pacific Coast Society of Orthodontists) has a common law requirement, *not* based on constitutional principles, to insure a "fair procedure" for determination of admission to its ranks.[7] The common law is the law of England and is the basis from which the laws of the United States and all of the individual states except Louisiana are derived. It is an important distinction that this case was determined by common law principles, because that does not involve an expansion of any constitutional principle; the theory should be more readily accepted than a constitutional one.

The case held that whenever a denial of admission to such a society would result in a deprivation of substantial economic advantage, there must be an established "fair procedure" that is followed. The economic deprivation in this case involved the referral system among the board-certified orthodontists. California allows dentists who are not board certified to practice orthodontics. The court compared the society to a trade union or guild which monopolizes the work available in a given specialty and traditionally has had such a requirement. There are numerous older cases mentioned by the court in its opinion, but the theory had not been widely applied in modern times. The American Association of Orthodontists was also a named defendant in the case.

All such professional societies should be aware of this holding. It may become necessary for them to develop a standard "fair procedure" to be applied to applications for certification or admission if they do not already have one. ■

REFERENCES

1. See generally, *Wood v. Hogan,* 215 F. Supp. 53 (W.D. Va., 1963). *Khoury v. Community Memorial Hospital,* 203 Va. 236, 123 S.E.2d 533 (1962). *Stanturf v. Sipes,* 244 F. Supp. 883 (W.D. Mo., 1963), *aff'd* 335 F.2d 224 (8th Cir., 1964), *cert. denied* 85 S.Ct. 676, 379 U.S. 977, 13 L.Ed.2d 567.

2. *Simkins v. Moses H. Cone Memorial Hospital,* 323 F.2d 959 (4th Cir., 1963), *cert. denied* 376 U.S. 938, 84 S.Ct. 793.
3. *Sams v. Ohio Valley General Hospital,* 413 F.2d 826 (4th Cir., 1969). *Christhilf v. Annapolis Emergency Medical Assn., Inc.,* 496 F.2d 174 (4th Cir., 1974).
4. See generally, *Ward v. St. Anthony Hosp.,* 476 F.2d 671 (10th Cir., 1973). *Ascherman v. Presbyterian Hosp.,* 507 F.2d 1103 (9th Cir., 1974).
5. *Spencer v. The Community Hospital of Evanston,* —— F. Supp. —— (N.D. Ill., 1975).
6. *Ascherman v. St. Francis Memorial Hospital,* 119 Cal. Rptr. 507 (Cal. App., 1975).
7. *Pinsker v. Pacific Coast Society of Orthodontists,* 81 Cal. Rptr. 623, 1 P.2d 495 (1972): 116 Cal. Rptr. 245, 526 P.2d 253 (*en banc,* 1974).

SIX GEORGIA HEALTH SERVICE AREAS RECOMMENDED BY GOV. BUSBEE

Governor George Busbee, in an announcement May 5, recommended that Georgia be divided into six health service areas, in compliance with the requirements of the National Health Planning and Resource Development Act, which was explained in detail in the March 1975 issue of the *Journal.* MAG had recommended to the Governor a division into seven areas, and technically Gov. Busbee had done this—three counties in northwest Georgia, Catoosa, Walker and Dade, were placed with the Chattanooga, Tennessee standard metropolitan statistical area (SMSA).

In detail the areas include:

1. A North Georgia area extending from Haralson County in the west to Hart County in the east. (500,200 population)

2. A North Central area including the Atlanta SMSA and the counties on a line to, and including, LaGrange. (1,964,000 population)

3. An East Central area including Athens, Augusta and Aiken County, S. C. as part of the Augusta SMSA. (565,000)

4. A Central Georgia area from Columbus through Macon and including Russell County, Alabama as part of the Columbus SMSA. (758,000)

5. Southwest Georgia with Albany as the health service hub. (518,600)

6. Southeast Georgia, including the Savannah SMSA. (522,100)



Russell County, Ala. is part of the 6th District; Aiken County, S.C. belongs to the 3rd District; the three northwest Georgia counties are part of Tennessee's HSAs.

Before deciding on the six area designation, Gov. Busbee sent 300 letters asking for input to mayors, community agencies and medical groups, and held a series of hearings in Savannah, Augusta, Macon, Atlanta, Albany and Columbus at which 500 persons testified. In setting up the HSAs, he had to take into consideration the population requirement—over 500,000 persons and under three million per area; the standard metropolitan statistical areas; geographic continuity; and already existing substate administration and planning areas.

Several alternate plans were suggested, but those favoring six areas felt this would allow more homogeneous local input and control and reduce travel expenses and time. Among the more disappointed health care providers were those in Columbus who wanted that city to be linked with Albany and not Macon as was done.

The Health Planning and Resources Development Act was signed into law January 4, 1975, and was designed to combine the "best" features of the Comprehensive Health Planning agencies, Regional Medical Programs and Hill-Burton agencies. It provides for a nationwide network of health service areas which have broad responsibilities. In essence the HSAs will determine the kinds of federal funds coming into the area, how the funds will be used, and who will oversee their use.

I've told this before . . .

(Ed. note: Luther Vinton, M.D. of Avondale Estates joins our growing list of contributors with this anecdotal account from his own practice. Contributions to this feature page should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Decoding the Complaint

ONE ESSENTIAL ELEMENT in medical history taking is the ability to understand what the patient is trying to tell you. Two outstanding instances come to mind from my earlier days.

The first was an evening telephone call from a distressed elderly lady of a more modest era informing me that her husband's water pipe was gone. Her reticence prevented any determination further than vague genital references and necessitated a house call. Examination of course clarified all. The poor old husband had experienced the customary diminution in size of his external urinary apparatus, but when coupled with the presence of two massive inguinal hernias left only a dimple where his water pipe had been. Reduction of the hernias restored the missing appendage and the equanimity of the wife.

The second equally late and distressed phone call from a younger lady confided that "her secrets were terrifying her to death." Only a boy raised in the deep South would have known that she needed, not a psychiatrist, but treatment for trichomonal vaginitis.

L. M. Vinton, Jr., M.D.
1043 Lakeshore Drive
Avondale Estates, Georgia 30002

HIGHLIGHTS OF COUNCIL

June 7, 1975

AMA Meeting on Malpractice, Chicago, July 9: Approved sending an MAG representative to attend this meeting.

Health Systems Agencies: Heard a discussion of the six HSA areas that have been designated for Georgia. The areas for Macon and Columbus are the most controversial, and Columbus intends to officially protest to HEW, although it appears unlikely that the Secretary will change Governor Busbee's recommendation. It was reported that the GRMP staff has been asked to assist various county medical societies in forming the HSAs. Meetings have been held in several areas, and other areas are anticipating meetings soon for the purpose of developing an application to be submitted to HEW. MAG will be kept advised of the developments.

Special Awards Given to MAG Members: Certificates of Appreciation were presented by the Composite State Board of Medical Examiners by Mr. Cecil Clifton, Joint Secretary of the Board, to Drs. J. Rhodes Haverty and William E. Lotterhos and Mr. David L. Glazer for their meritorious service to the Board.

Georgia Medical Assistance Program Policies and Procedures for Physician Services and Provider Agreement: Discussed at length the various ramifications of these proposed changes and additions to the Medicaid Rules and Regulations. Appointed a committee to work with the Board of Human Resources to bring about changes in these new Rules and Regulations to make them relate more closely and be more realistic to the practice of medicine in Georgia. If the Committee is unsuccessful in its negotiations with DHR, then a special meeting of Council will be called during the summer to determine future MAG policy on the issue.

Professional Liability: Heard a comprehensive report by the Chairman of the Committee on Professional Liability which outlined the problem in Georgia and suggested the number of alternative solutions. The Committee on Professional Liability Insurance and the Committee on Legislation were directed to continue their study of the problem and present recommendations to the Council at the September meeting as to the position that MAG should take.

PSRO Amendments: Endorsed the 19 amendments to the PSRO as proposed by the American Medical Association.

GaMPAC: It was reported that total membership is below the number this time last year but that Auxiliary membership had increased twenty-fold.

Date and Site of Next Regular Meeting: September 13-14, 1975, Jekyll Island, Sand Dollar Motel.

the association
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the association

NEW MEMBERS

Abellera, E. M., Clayton-Fayette—Act—Su
5330 Warrington Place, College Park 30349

Aseron, Cirilo, Jr., Richmond—Act—R
Medical College of Georgia, Augusta 30904

Bautista, Grace C., St. John's Parish—Act—Pd
P.O. Box 406, Fraser Drive, Hinesville 31313

Bautista, Victor C., St. John's Parish—Act—Anes
Liberty Memorial Hospital, Hinesville 31313

Brown, James A., Richmond—Act—Oph
1445 Harper St., Augusta 30902

Cousins, Albert L., Troup—S—I
303 Smith St., LaGrange 30240

Elsea, William R., MAA—Act—PH
99 Butler St., S.E., Atlanta 30303

Fleisher, Alan S., MAA—Act—NS
80 Butler St., S.E., Atlanta 30303

Freyre, Robert C., Newton-Rockdale—Act—FP
943 Court St., Conyers 30207

Funk, Sidney A., MAA—Act—ObG
275 Carpenter Dr., Atlanta 30329

Haar, Floyd L., Richmond—Act—NS
Talmadge Memorial Hospital, Augusta 30902

Hacker, Mortimer, MAA—Act—FP, Path
1330 W. Peachtree St., N.W., Atlanta 30309

Jackson, Robert W., Thomas Area—Af—OrS
P.O. Box 978, Thomasville 31792

Lemon, Roman, Jr., Richmond—Act—ObG
3651 Wheeler Road, Augusta 30904

Moore, G. Richard, MAA—Act—ObG
1702 Cleveland Ave., East Point 30344

Oxford, William M., Upson—Act—Su
405 W. Main St., Thomaston 30297

Ramos, Fernando Q., Whitfield-Murray—Act—Su
120 Walnut St., Chatsworth 30705

Sorsdahl, Oliver A., MAA—Act—R
300 Boulevard, N.E., Atlanta 30312

Ward, M. Terry, MAA—Act—Em
1405 Shadowood Parkway, N.W., Atlanta 30339

Warren, Howell R., MAA—Act—P
1970 Cliff Valley Way, N.E., Atlanta 30329

Wyson, Edward D., Wilkes—Act—FP
123 Gordon St., Washington 30673

SOCIETIES

The **Bibb County Medical Society** at its monthly meeting July 1 heard Kenneth C. Henderson, M.D., neonatologist and chief of pediatrics at MCG, speak on "New Neonatal Intensive Care Nursery."

Former POW Porter Halyburton discussed his experiences as a prisoner of the North Vietnamese before the June 16 meeting of the **DeKalb County Medical Society.** The malpractice crisis was to be the subject of the society's July meeting with Johnny Caldwell, state insurance commissioner, speaking on a panel with William Moore, M.D., chairman of MAG's Insurance Committee, and Steve Manthe, vice-president of the St. Paul Company. L. C. Buchanan, M.D. was to moderate the panel.

The **Dougherty County Medical Society** hosted the Neal Memorial Lecture at the end of June with 300 hearing an address by Dr. Frank Netter, world famous medical illustrator. Dr. and Mrs. Charles Gillespie hosted Dr. and Mrs. Netter during their stay in Albany which included a visit to Pineland Lodge, Tarva Plantation, a talk before art and nursing students at Albany Junior College and a television interview. The Lake Worth, Florida physician is known for his published illustrations and texts. He was trained at the New York National Academy of Design and New York University Medical College.

Dr. Harold Meryman, director of the National Red Cross Blood Research Laboratory in Washington, D.C. spoke on "Frozen Blood" at the June 10 meeting of the **Georgia Medical Society** in Savannah.

PERSONALS

First District

Edgar J. Filson of Savannah was conferred the degree of Fellowship of the American College of Nuclear Medicine during the society's annual meeting in Orlando, Florida in April.

Keith Dimond, Savannah, has been certified as a Diplomate of the American Board of Internal Medicine in the subspecialty of nephrology. His associate, Paul F. Jurgensen was certified as a diplomate of the Subspecialty Board of Infectious Diseases. Dr. Jurgensen is chairman of the Infectious Control Committee at Memorial Medical Center in Savannah and is clinical assistant professor of medicine at the University of Florida College of Medicine in Gainesville, Florida.

Two Savannah physicians, **Thomas Freeman** and **Irving Victor,** have been named to a steering committee of six people for Chatham County which will form an advisory council aimed at implementing national health care legislation and Health Systems Agencies.

New MAG member **Ruben D. Silan** has begun

practice in Hinesville, working part time at Liberty Memorial Emergency Department. Dr. Silan previously served as chief resident in general surgery at St. Vincent Medical Center of Richmond in New York City.

Ivy L. Shuman, Jr. of Savannah is one of 16 physicians in the South named a recipient of a Southern Medical Association residency training loan.

Third District

Columbus physician **John D. Watson, Jr.** has been conferred the Degree of Fellowship of the American College of Nuclear Medicine in ceremonies at the annual meeting of the Association April 18-20.

The Albany Lions Club has selected **Charles R. Gillespie** as citizen of the year for his service to the community and his profession. Dr. Gillespie is active in the Chamber of Commerce, is on the staffs of Albany Orthopedic Clinic, and Palmyra Park and Phoebe Putney hospitals, and is a fellow of the American College of Surgeons. The Emory graduate is a native of North Carolina.

A feature story in the *Warner Robins Daily Sun* has honored **A. G. Hendrick** of Perry for his years of service to the community on the occasion of National Hospital Week. The article quotes praise from one nurse who works with Dr. Hendrick: "Before the Perry hospital was built, Dr. Hendrick would travel all the way from Perry to help deliver babies. Sometimes he would drive the mother himself. And he always gave the best care to each of his patients whether they could pay or not. In my book, he's one of the best because he cares."

Columbus radiologist **J. H. Walker Harris** recently traveled to Monte Carlo and Paris to participate in the International Physicians' Tennis Association Annual Tournament. He returned as the international veterans (over 45) doubles champion and was runner-up in the singles competition. The Association has over 10,000 members.

Fourth District

Bill Hardcastle of Decatur, president of the Georgia Lawn Tennis Association, recently participated in the Atlanta City Open Tennis Tournament and was runner-up in the 35 and older division.

Fifth District

Milton Bryant of Atlanta was featured in an article titled, "Expert Advice from the Snakebite Doctor," in the May 18 issue of *The Atlanta Journal and Constitution Magazine*. Dr. Bryant's article on snakebite and how to treat it appeared in the April issue of *JMAG*.

Atlanta orthopedic surgeon **Joseph H. Dimon, III,** spoke on "New Advances in Surgery in Arthritis" at a public forum in Savannah sponsored by the Savannah branch of the Arthritis Foundation. Dr. Dimon is a member of the Governor's Conference on Arthritis and a member of the executive committee of the Georgia Orthopedic Society.

Charles A. Eberhart, Sr. was the special honoree June 6 at the annual dinner meeting of physicians who have graduated from the training program in urologic surgery at Emory University and its affiliated hospitals. Before his retirement, Dr. Eberhart was resident supervisor in charge of the training program at Crawford Long Hospital and pioneered the uro-dynamics laboratory there.

Alan O. Feingold of Atlanta is the author of "Tuberculosis Without Fever" in the June *Southern Medical Journal*. **William E. Huger, Jr.,** Atlanta, wrote "Avoidable Pitfalls in Augmentation Mammaplasty" for that publication.

Guest speaker at the June meeting of the Atlanta Press Club was **James A. Kaufmann,** Atlanta internist and cardiologist, who presented an "expose of malpractice insurance and other medical costs." Dr. Kaufmann serves as chairman of MAG's State Legislative Committee.

John H. Ridley, Atlanta, served as visiting professor May 29 through 30 at Walter Reed Army Medical Center in Washington, D.C., with duties such as delivering lectures and conducting operative clinics.

Charles E. Todd of Atlanta will represent physicians in active practice on the 36-member Board of Directors for the National Association of Blue Shield Plans. He was recently elected to a two-year term on the Board. The Emory graduate has been a member of the Board of Directors of Blue Shield of Georgia/Atlanta, Inc. for two years and is the current chairman.

MAG members recently elected to the 1975-76 medical staff of Atlanta Hospital include: **William Smith,** vice president and chief of ENT; **Stewart Atkinson,** secretary and chief of ophthalmology; **T. L. R. Bower,** chief of anesthesiology; **William T. Weaver,** chief of surgery; **John T. Godwin,** chief of pathology and **A. A. Rayle, Jr.,** chief of radiology.

Sixth District

Macon physician **Z. Sweeney Sikes** was named a Life Fellow of the American Psychiatric Association at its May meeting in Anaheim, California, and is the new program chairman for the Southern Psychiatric Association.

Larry Freant of Macon has become one of only 300 physicians in the world board certified by the American Board of Thoracic and Cardiovascular Surgery.

Seventh District

Veteran Rome physician **Robert Harbin** retired after 45 years of practice in that city June 1 and was honored at a surprise party at the Harbin clinic. Dr. Harbin received his medical degree in 1928 from Emory University and interned at Peter Bent Brigham Hospital in Boston, Mass. Upon entering the practice of medicine he joined The Harbin Hospital, a medical organization founded by his father, R. M. Harbin, Sr., M.D., and uncle, William P. Harbin, Sr., in 1908. The Harbin Clinic was formed in 1948. He is a trustee of the First Presbyterian Church and served as director of the First National Bank of Rome 19 years.

Marjorie Lyntt has resigned her position as Cobb County health director and accepted a residency at Grady Memorial Hospital in Atlanta.

Eighth District

Gov. George Busbee has appointed St. Marys physician **Carl Drury** to the newly constituted Coastal Zone Management Communication Forum concerned with

the beneficial use, protection and development of the state's coastal areas.

Tenth District

Lois T. Ellison has been named provost of the Medical College of Georgia and will function as chief advisor to the president on inter-institutional affairs. Dr. Ellison is a graduate of the Medical College and has served on its faculty since graduation. Last year she was named associate dean for curriculum for the School of Medicine.

Paul D. Webster, professor of medicine and gastroenterology at the Medical College of Georgia, has received a $64,000 grant from the National Institute of Arthritis, Metabolism and Digestive Diseases.

A typical day in the life of Sparta family physician **George Green** was featured in a half page story in the June 17 *Atlanta Constitution.*

Carl Jelenko, III has been elected to the Board of Directors of the Georgia Chapter of the Emergency Physicians.

Kenneth D. Jones has been elected president of the Meadow Garden Hospital medical staff in Augusta. The MCG graduate is a fellow of the American Psychiatric Association. New vice president is **Jere Chambers** and **Ben Moss** is secretary.

Herbert E. Brizel, Augusta, is newly elected a Fellow of the American College of Nuclear Medicine.

DEATHS

James Kenneth Adams

Jefferson physician James Kenneth Adams, 51, died May 16. The Hart County native was graduated from the University of Georgia, Phi Beta Kappa, and the Medical College of Georgia. He was a veteran of World War II.

Survivors include his widow, Mrs. Martha Brooks Adams; three daughters, Mrs. Patty Hayes of Hoschton, Mrs. Paul Booth and Miss Kenyal Adams of Jefferson; parents, Mr. and Mrs. James K. Adams of Hartwell; sister and brother.

Pleasant L. Collinsworth

Retired Atlanta physician Pleasant L. Collinsworth, 64, who had moved his residence to St. Augustine, Florida died June 16. Dr. Collinsworth has specialized in industrial surgery for 25 years. He was a graduate of the University of Georgia and the Medical College of Georgia and was one of the founders of Industrial Clinic Professional Association. During World War II he was an officer in the U.S. Army Medical Corps.

Survivors include his widow, the former Ruth Brown; daughter, Mrs. Carole Maudlin; and son, Phillip L. Collinsworth, both of Smyrna.

C. E. Cunningham

C. E. Cunningham, 74, who had worked in a mission hospital in Colombia since his retirement from practice in 1972, died June 19.

Dr. Cunningham was a graduate of Davidson College and received his medical degree from Johns Hopkins University. He served as a Decatur physician from 1934 to 1972 and was an honorary member of the DeKalb Medical Society. He was a member and elder of the Decatur Presbyterian Church.

He is survived by his son, Charles E. Cunningham, Jr., of Atlanta; and sisters, Mrs. Clifford Anderson of Decatur, Mrs. Eldred Cayce of Nashville, Tenn. and Mrs. John Richards of Elko.

Walter R. Holmes

Retired Atlanta obstetrician and gynecologist Walter R. Holmes died in an Atlanta hospital June 11 at the age of 87. Dr. Holmes was born in Macon, but had lived and practiced in Atlanta most of his life, retiring in 1972.

He was a Phi Beta Kappa graduate of the University of Georgia and received his medical degree from Johns Hopkins University. He later served as assistant resident and instructor at the University. In 1920 Dr. Holmes began practice and was a visiting instructor at Emory for many years.

Active in organized medicine, Dr. Holmes was a member of the Southern Society of Clinical Surgeons, the Southern Surgical Association, Southeastern Surgical Association, the Southern Atlantic Association of Obstetricians and Gynecologists and the American Association of Obstetricians and Gynecologists. He was a member of St. Marks United Methodist Church, the Piedmont Driving Club and the Capitol City Club.

He is survived by his widow, Mrs. Idelle Palmour Holmes of Atlanta; two daughters, Mrs. Pope B. McIntire of Atlanta and Mrs. Ellis Murphy of Spartanburg, S.C.

Robert Lee Rogers, Sr.

Robert Lee Rogers, Sr., 83, of Gainesville, long active in community and political activities, died June 1 after a brief illness.

Dr. Rogers was graduated from North Georgia College in 1914 where he was a member of Sigma Nu fraternity. He was named to the College's Hall of Fame in 1974 and was active in alumni affairs, serving on the board of trustees.

In 1919 he was graduated from Emory University School of Medicine, and served his internship at Grady Memorial Hospital in Atlanta and in Charleston, W. Va. He began practice in Gainesville in 1922, and was active in establishing the present Hall County Hospital.

He served for a while as chairman of the State Board of Health and was a member of the President's Committee for Employment of the Handicapped.

Dr. Rogers was a member, past president and past district director of the Civitan Club and served as chairman of the Civitan International Committees on Scholarship and Aid to the Handicapped. He was a member of the Gainesville Masonic Lodge, No. 219, was a Shriner and member of the Yaarab Temple.

Active in politics, Dr. Rogers served on the State Democratic Executive Committee and on the staffs of all but one Georgia governors since 1933.

Survivors include his widow, Mrs. Ruth Carter Rogers; daughter, Miss Elizabeth Ann Rogers of Atlanta; son, Dr. Robert Lee Rogers, Jr. of Lenoir, N.C.; grandchildren.

Hyman B. Stillerman

Hyman B. Stillerman, 60, director of the environmental health department of Crawford W. Long Hospital, died May 19. He was a Phi Beta Kappa graduate

of City College of New York and earned his medical degree at Washington University in St. Louis, Mo.

During World War II, he served as a captain in the U. S. Army Medical Corps. Dr. Stillerman is a fellow in the American College of Internal Medicine and was an associate professor of medicine at Emory University. He was a deacon in the Beecher Hill Baptist Church and a founder and former president of the Board of Directors for Arlington Schools.

Dr. Stillerman is survived by his widow, the former Marguerite Mathias; daughter, Mrs. Carl E. Bolson of Jonesboro; sons, David P. Stillerman of Atlanta, the Rev. William B. Stillerman of Mt. Gilead, N.C., James D. Stillerman of Atlanta; and brothers.

OPPORTUNITIES FOR CONTINUING MEDICAL EDUCATION

HYPERTENSION CONFERENCE
August 8-9, 1975
Arranged by the Medical Association of the State of Alabama and Sponsored by CIBA Pharmaceuticals
19 S. Jackson St., Montgomery, Ala. 36104
Held in Eufala, Ala.

GEORGIA UROLOGICAL ASSOCIATION ANNUAL SCIENTIFIC MEETING
August 14-16, 1975
Hilton Head, S.C.
Contact: Robert B. Quattlebaum, Jr., P.O. Box 3458, Savannah, Ga. 31403

RURAL HEALTH CONFERENCE
August 27-28, 1975
Macon Hilton
Sponsored by MAG, Georgia Farm Bureau Federation, and the Cooperative Extension Service of the University of Georgia

GEORGIA SOCIETY OF OTOLARYNGOLOGY ANNUAL SCIENTIFIC MEETING
August 28-30, 1975
Point Clear, Ala.
Held with the Alabama and Tennessee societies
Contact: John C. Howard, M.D., 317 E. Hall St., Savannah, Ga. 31401

PROBLEM-ORIENTED RECORD POSTGRADUATE COURSE
September 8-11, 1975
Royal Coach, Atlanta
Emory University School of Medicine

OPHTHALMOLOGY
September 12-13, 1975
Contact: Division of Continuing Education, MCG, Augusta, Ga. 30902

GEORGIA HEART ASSOCIATION 27TH ANNUAL SCIENTIFIC SESSION
September 12-14, 1975
Royal Coach Motor Hotel, Atlanta
Sept. 12: Cerebral Vascular Disease;
Sept. 13: Permanent Cardiac Pacemaking, Cardiology Problem Solving;
Sept. 14: Congenital Heart Defects

FLORIDA ALLERGY SOCIETY FALL MEETING
September 19-21, 1975
Innisbrook Resort and Golf Club
Contact: Heinz J. Wittig, M.D., Box 739, University of Florida College of Medicine, Gainesville, Fla. 32610
Fee: $25

NATIONAL CANCER CONFERENCE ON CANCER RESEARCH AND CLINICAL INVESTIGATION
September 20-22, 1975
Regency Hyatt House, Atlanta
Contact: Evadne Gerrard, American Cancer Society, 219 E. 42nd St., New York, N.Y. 10017

SECOND ANNUAL CARDIOVASCULAR SYMPOSIUM
September 25-27, 1975
Gainesville Hilton Inn, Gainesville, Fla.
Contact: Howard W. Ramsey, M.D., North Florida Regional Hospital, P.O. Box 13494, Gainesville, Fla. 32604

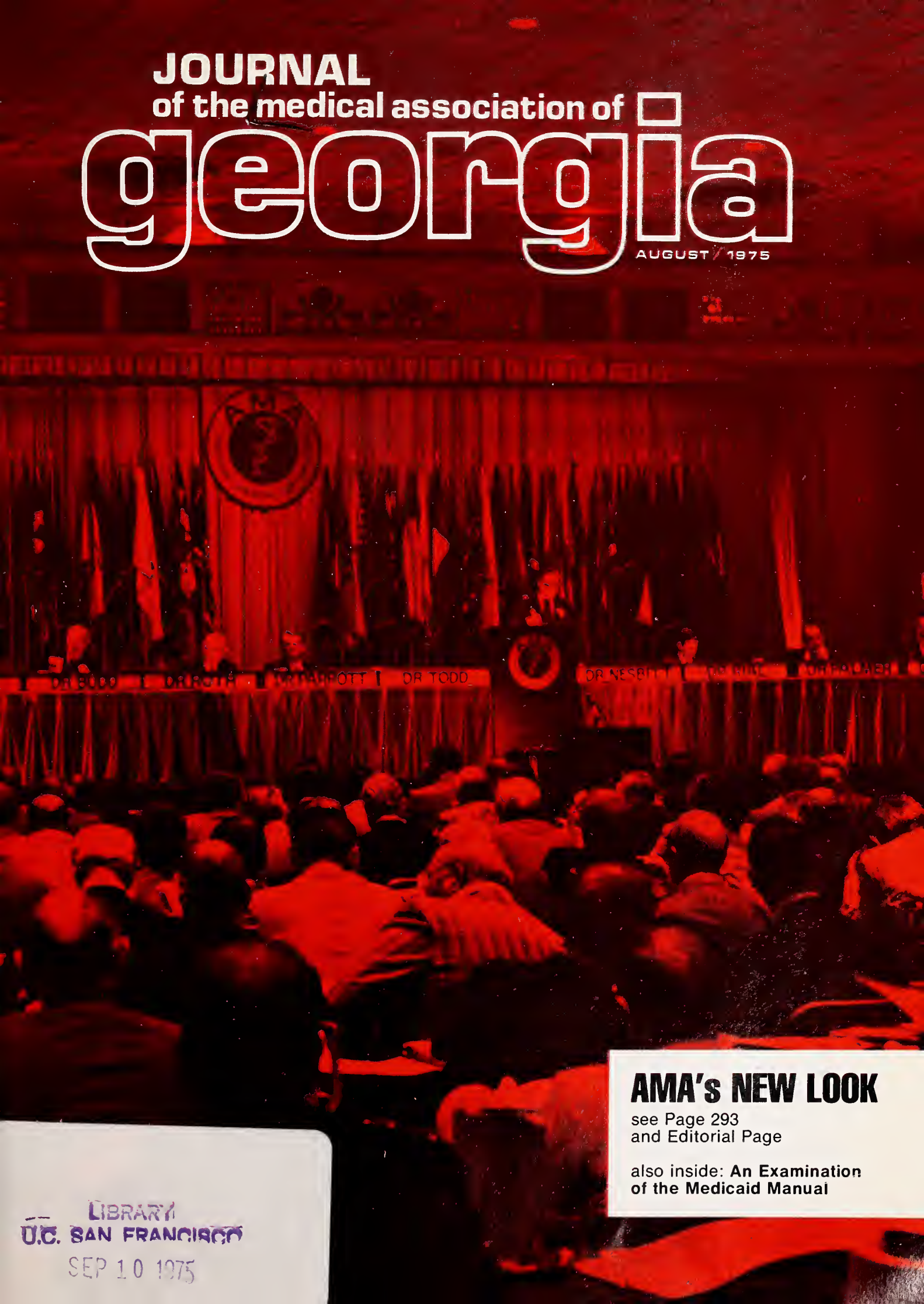
SCIENTIFIC FOUNDATIONS FOR CLINICAL PRACTICE
September 26-28, 1975
Fee: $45
Contact: Frank R. Lemon, M.D., Office of Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506

AMERICAN THERMOGRAPHIC SOCIETY ANNUAL MEETING
September 27-28, 1975
Marriott Motor Hotel, Atlanta
Contact: Georgia Revesz, Temple University School of Medicine, Radiology Research Laboratory, 3401 N. Broad St., Philadelphia, Pa. 19104

SOCIETY FOR PEDIATRIC RADIOLOGY
September 28-29, 1975
Marriott Motor Hotel, Atlanta
Contact: J. P. Dorst, M.D., Johns Hopkins Hospital, 601 N. Broadway, Baltimore, Md. 21205

AMERICAN ROENTGEN RAY SOCIETY
September 30-October 3, 1975
Marriott Motor Hotel, Atlanta
Contact: James F. Martin, M.D., 300 S. Hawthorne Road, Winston-Salem, N.C. 27103

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of the medical association of
georgia
AUGUST / 1975



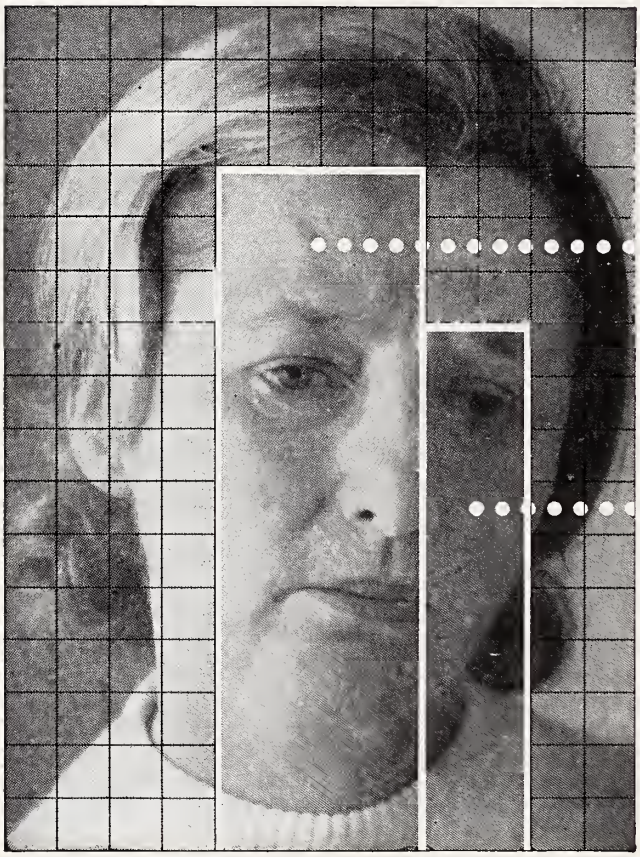
AMA's NEW LOOK

see Page 293
and Editorial Page

also inside: **An Examination of the Medicaid Manual**

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JOURNAL
of the medical association of georgia

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VOLUME 64, NUMBER 8

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Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1975, Medical Association of Georgia.

Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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THE COVER

AMA delegates, meeting in Atlantic City in June, dealt with difficult problems facing the organization and facing the practice of medicine in general. As the Highlights on page 293 and Editorial on page 315 show, responsible decisions were made that may give organized medicine a "new look." Layout by Bob Hamill, Atlanta. AMA photograph by Joe Fletcher.

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Highlights of AMA House of Delegates Actions

In the most momentous session to be held in decades, delegates at the 124th Annual Convention June 14-19 in Atlantic City urged vigorous AMA action in a number of medical problem areas—including malpractice and federal intervention—and then approved a substantial dues increase to assure the necessary financial support.

Meeting for 22 hours and 37 minutes, the longest Convention in recent memory, the House acted on 73 reports and 168 resolutions for a total of 241 items of business.

Repeatedly emphasizing stronger AMA involvement in confronting problems facing local physicians, an overwhelming majority of the House voted to raise annual dues of regular members to $250, intern-resident dues to $35, and to maintain student dues at $15.

Elections

Delegates selected Richard E. Palmer, of Alexandria, Virginia, as president-elect. Others elected or re-elected to positions in the Association were: Vice-President, George W. Slagle, Michigan; Speaker of the House, Tom E. Nesbitt, Tennessee (re-elected); Vice-Speaker of the House, William Y. Rial, Pennsylvania (re-elected); Trustees, for 3-year terms—Joe T. Nelson, Texas (re-elected); Robert Hunter, Washington (re-elected); Jere W. Annis, Florida (re-elected); Joseph M. Boyle, California. For the unexpired two-year term of Richard E. Palmer, named President-Elect, Lowell H. Steen, Indiana.

Inaugural Address

In his inaugural address on Wednesday, June 18, Dr. Max H. Parrott, the new AMA president, said that "the great national debate on health and medical issues is a clash between (government) utilitarianism and (medical) humanism."

In viewing medical care as a commodity rather than a service, Dr. Parrott said, "the health care planners and regulators see medical care as little more than a numbers game. . . . If only the commodities of health care can be more efficiently organized, assembly-line style, if only the providers of care can be better coordinated as a work force, then the consuming public will be eternally blessed."

And efficiency in providing such a "commodity," Dr. Parrott emphasized, is the intent of such government programs as PSROs and HMOs.

"But," he warned, "medically speaking efficiency . . . optimum production at the least cost in time and money . . . means something far different from quality."

Such efficiency could in truth subvert quality of medical care, which he defined as "giving the best appropriate service . . . regardless of the time required . . . and regardless of cost."

The AMA, Dr. Parrott stressed, "has much to say about the plain truth that medical action depends on the freedom to act, rather than on regulation.

"We have so much to say about the clear prospect that in any squeeze play between federal regulators of medicine and the regulated, the patient, too, will be crushed.

"We have so much to do and say in Washington and across the land. And so little time. We want an AMA spirited enough to save the individual spirit of medicine and preserve the quality of care . . . determined enough that medicine will serve no master except service itself."

And the best way to maintain a spirited and determined AMA, according to Dr. Parrott, is to give it "a voice which is clear and distinct amid the hubbub of controversy."

Thus Dr. Parrott called for the abolishment of the offices of AMA president, president-elect, vice-president, and immediate past president.

He further urged that the speaker and vice speaker of the House of Delegates be given votes on the

Board of Trustees, and that the chairman of the board be elected directly by the House after nomination by the Board.

"Hence," Dr. Parrott said, "the chief leaders—and chief spokesmen—of the AMA would be the board chairman, acting for the elected officers and the House, and the executive vice-president, acting for the staff."

Such a streamlining would result in a continuum of Association experience and policy, Dr. Parrott said. His recommendations were referred to the Council on Long Range Planning and Development, which is studying a possible reorganization of the AMA.

A reorganization of the AMA at its top level is necessary, Dr. Parrott said, if the Association is to achieve its overriding goal: maintaining the high quality of care.

Final Remarks by Malcolm H. Todd

"Future shock" has created an "identity crisis" in American medicine, including the AMA, according to Malcolm C. Todd, AMA president, who gave his final report to the House on Sunday, June 15.

"Future shock," Dr. Todd said, "has hit our Association so abruptly, so hard, and in so many ways, that it has caused an identity crisis. Physicians wonder what the American Medical Association is today."

To remedy that, he suggested that continuity be established between past, present and future so the strengths of tradition could be drawn upon to make the future more solid.

Thus he said physicians must understand that the AMA, in coping with its own future shock, "is not abandoning its historic goals, but merely updating them."

And Dr. Todd urged that the AMA focus substantial energies on "quality of care—the objective for which this association was founded." The major thrust of this effort should be towards education, especially continuing education.

In support of that thrust, he asked delegates to consider AMA establishment of a "university without walls for continuing education."

"Operating in coordination with the medical schools, this university might confer an advance degree after a full year of educational activity. Through its university status and its conferral of degrees, it would lend a new image and a new prestige to continuing education," Dr. Todd said.

Dr. Todd called for a re-emphasis in medical schools on the training of men and women to practice medicine, rather than the growing emphasis on research and the training of researchers.

The National Institutes of Health, he said, are the logical pathways to research, and urged that the AMA legislatively support increased funding and physician involvement in the institutes' advisory bodies.

Several other areas call for decisive political action by the AMA, he said. "Medicine no longer can enjoy the privilege of being a sanctum. . . . Politically, a steady stream of legislation—such as PSRO, HMO, public utility type legislation, and health manpower bills—has fallen upon our heads in heavy drops, like the water torture of the ancient Chinese.

"Often more important than the laws, are the highhanded regulations they entail—such as those on utilization review. Without any authorization from the U.S. Constitution, the regulatory agencies have become so powerful that I call them the fourth branch of government."

Thus, Dr. Todd said the AMA must be concerned with "Big Brother" government. At the same time, he said, the AMA must support health programs to benefit all the "little brothers in America."

So he concluded that, "This Association must have the full support of our profession—numerically, morally, and financially. Otherwise it cannot do what it has to do, and we, as a profession, cannot do what we have to do."

Association and Internal Matters of the House

Dues Increase and Related Priorities: In increasing annual dues of regular members from $110 to $250, delegates also served clear notice of a new and aggressive stance by the AMA in dealing with the many problems facing the nation's physicians.

By adopting the $250 dues level recommended by the Board, the House was assured that depleted financial reserves would be restored, that present programs would be continued, and that additional programs—such as those for malpractice and to combat growing government presence—would be mounted. In related actions, the House called for:

- Balanced budgets in both accounting and program formats.
- Intensified membership recruitment and retention efforts.
- Continued administrative support of AMPAC.
- Annual reports on the status of AMA fixed assets and investments.

In just one of the problem areas discussed—malpractice—the House called for the AMA to take immediate actions to help ease the crisis, including the formation of an AMA-sponsored professional liability reinsurance company.



A thoughtful Georgia delegate, John S. Atwater, M.D. of Atlanta listens to debate on the floor of the AMA's 12th Annual Convention in Atlantic City. Other members of the Georgia delegation are J. Daniel Bateman of Albany, J. W. Chambers of La-Grange and Harrison L. Rogers of Atlanta. (AMA photograph by Joe Fletcher.)

The company will provide backup or second-level coverage for those state medical societies that have sponsored their own medical liability insurance programs.

Meanwhile, delegates unanimously endorsed a substitute resolution applauding the recent suit filed by the AMA against HEW regulations which mandate post-admission certification of hospital patients, and left no doubt that a primary reason for approving the dues increase was to provide fiscal support not only for the present suit, but for similar actions as well. Thus the second resolve of the resolution reads:

"That the Board be encouraged to continue to take such action in the future on further legislation or government regulations that threaten the ability of physicians to provide quality medical care to patients."

The House was appraised of the fact that Trustees have instructed the AMA Office of General Counsel to lay the legal groundwork for possible suits against the new federal health planning program, HEW regulations for the proposed "Maximum Allowable Cost" purchase of drugs, and for objectional features of proposed health manpower legislation should those features be enacted.

In other priorities related to the dues increase, the House called for continuing efforts to re-build the AMA on a sound financial basis, and strongly supported a reshaping of the AMA publishing program as well as a restructuring of the organization itself.

Advertising-Publications: Acting on further information provided by the Special Committee of the House appointed at Portland last December, delegates endorsed "a policy of aggressive advertising promotion" in AMA publications and asked the Board to implement this policy at the earliest possible time.

In other actions, the House urged that the 10 specialty journals be placed on a self-sustaining subscription basis, or that appropriate arrangements be reached with the specialty societies involved.

Upon questioning by trustees, however, the House made it evident that it will be left to the Board to determine the eventual fate of *Prism,* so long as the disposition is to the financial advantage of the AMA.

This interpretation emerged as the result of a special consultants' report to the House on Sunday, June 15, when it was pointed out that AMA publications are valuable properties which should be handled like other Association assets. In short, *Prism* could be sold, or it could be continued if it could be put on a paying basis.

The House also authorized the Board to set subscription rates for all publications—including *Today's Health*—excepting only *JAMA* and *American Medical News.*

Organizational Structure: The House endorsed the concept of restructuring the AMA, including Councils and Committees, and directed its Council on Long Range Planning and Development to submit a definitive report at this fall's Clinical Meeting in Honolulu.

Key elements in the report are expected to be the 1975 AMA Plan, and its clustering of AMA priori-

ties into five major areas, organizational structure; resolving the malpractice crisis; fighting increased government intervention; maintaining AMA's leadership role in medical education; and strengthening AMA resources.

Physicians and the Government

Reimbursement Under Government Health Programs: The House strongly reaffirmed the AMA's long-standing position that physicians participating in government health insurance programs should be reimbursed on the basis of usual, customary and reasonable charges.

In a further step, Delegates requested the Council on Medical Service to examine the Medicaid and Medicare programs to see if reimbursement did meet AMA policy, and to report back at the Honolulu Clinical Meeting.

The House also adopted report JJ of the Board, which updates Board actions in objecting to the proposed payment of usual, customary and reasonable Medicare fees based on a national economic index as recently promulgated in regulations published in the Federal Register.

The Board report emphasizes continued and vigorous opposition to the proposal, including legal action should it become necessary.

Federal Health Planning Program: The House unanimously supported the Board in its recent actions to oppose implementation of the National Health Planning and Resource Development Act enacted by the last Congress.

The delegates pledged support for "any action, including legal action," that the Board deems appropriate and effective in preventing implementation of the new planning law.

PSRO Policy Reaffirmed: Delegates reaffirmed present AMA policy on PSROs, and defeated a call for repeal of the PSRO law. After discussion in reference committee and on the floor of the House, delegates reaffirmed PSRO policy adopted at the 1974 Annual Convention.

The policy basically calls for AMA action to seek constructive amendments to the law and appropriate regulations and directives, and to support continued monitoring of the program. The policy also holds that should the PSRO program become too restrictive, however, the Board can seek repeal. And here again, the House cited the possibility of legal opposition if it becomes appropriate.

Physicians and the Public

Professional Liability Proposals: In endorsing a series of proposals aimed at mitigating malpractice problems, the House stressed that the continued ability of physicians to provide care to patients was a prime motivating factor.

While adopting a substitute resolution supporting the use of "all available legal means" by local physicians in seeking reforms in professional liability insurance, for example, it was emphasized that work slowdowns were basically a commitment to continued patient care rather than personal financial gain in the traditional sense of a strike.

The final version of the resolution reads: "The AMA recognizes that physicians are entitled to use all available legal means, without jeopardizing the medical care of their patients, to protest when intolerable and unwarranted burdens are placed upon their patients, the Association, or its members."

The resolution also recognizes that "the primary commitment of the AMA and its physician members is to the essential medical needs of the people of this nation."

In other malpractice actions, the House urged renewed AMA assistance to state societies in seeking legislative enactment, and public endorsement of, mechanisms such as voluntary arbitration plans, and changes in tort law to relieve statutory elements which contribute to malpractice problems.

The House also reaffirmed its stand against claims-made types of insurance coverage, and voted to encourage the federal government to provide coverage for physicians employed by government.

National Health Insurance: Delegates supported the national health insurance bill of the AMA which has been introduced in Congress. The bill would provide both basic and comprehensive benefits for all Americans, but would minimize federal administration and financing.

During a health insurance debate in the House, considerable sentiment was expressed for a national catastrophic insurance coverage program, but the subject was referred to the Board for further study.

In other actions related to Physicians and the Public, the House endorsed legislation to permit Social Security recipients to earn unlimited income without a reduction in retirement benefits.

Physicians, Hospitals and Medical Schools

Medical Staff Prerogatives in Patient Care: Several actions aimed at preserving hospital medical staff prerogatives in patient care were endorsed by the House.

A joint report of the Councils on Medical Education and Medical Service provided a detailed study of possible medical staff problems posed by the increasing appointment of salaried chiefs of staff and department heads by hospital governing bodies.

The report pointed out that medical staff rights

and prerogatives could be thus shifted to governing boards, and made several recommendations for local medical staffs and medical societies to counter the trend. Delegates adopted the report.

The House also endorsed a Board report urging AMA members on the Joint Commission on Accreditation of Hospitals to seek to amend JCAH standards to provide due process for physicians employed in medico-administrative positions.

In related actions, Delegates supported measures to prevent local or regional duplication of JCAH functions, and urged that JCAH be requested "to limit requirements for medical audit or other quality assurance activities by medical staffs" to those whose necessity can be "documented" by the AMA Board of Trustees.

Foreign Medical Graduates: The House endorsed a continuation of the fifth pathway concept of the AMA for determining the qualifications of FMGs, rejecting a proposal to eliminate the program.

On other matters related to FMGs, the House requested additional information for consideration and possible action at the 1975 Clinical Meeting.

Medical Schools: The House voted to continue opposition to medical manpower legislation now before Congress which would require medical students to repay capitation grants to their schools or else provide "in-kind" service in areas stipulated by government, and which would provide federal control of the number and distribution of residencies.

Miscellaneous Actions

Miscellaneous House actions include:

- Approval of Annual Conventions in St. Louis, 1978; in New York, 1979; in Las Vegas, 1980; in San Francisco, 1981; and in Dallas, 1982.
- A recommendation that medical schools recognize contributions of women in medicine and promote equal opportunities for them in education and in practice.
- Adoption of a Board report defining planned patient education programs and suggesting they be reimbursable under health insurance.
- A recommendation that all medical students be given opportunities for primary care experiences in inner city or rural areas.
- Support for continued AMA involvement in the evaluation of services to be provided by emerging health occupations, and in judging the appropriateness of each occupation. ■

STUDY OF EMORY UNIVERSITY MEDICAL GRADUATES SHOWS MANY RETURN TO SMALLER COMMUNITIES

You can keep them down on the farm after they've been in medical school, according to a study of Emory medical school graduates. Medical students who come from smaller communities are much more likely to return to them to practice than graduates from larger cities, a study of five Emory medical school classes has revealed.

Seventy per cent of the graduates in the period 1960-64 gave permission for their records to be used in the study which was conducted by John Hammond, doctoral candidate in sociology at Emory.

"There is a strong positive association between the original size of the community of residence and present practice location," said Dr. William M. Marine, professor of preventive medicine at Emory, and a member of the committee supervising the study.

"Forty-five per cent of Emory students in 1960-64 came from communities of under 25,000 population, 64 per cent from communities under 100,000 and now 34 per cent of them practice in communities under 25,000 and 56 per cent in communities under 100,000," Dr. Marine said, quoting statistics from Mr. Hammond's study.

"This data lends strong support for the size of community origin being the major determinant of the size of community of practice in spite of attending medical school in Atlanta and usually having residency training in large metropolitan areas," Dr. Marine said.

"Congress is in the process of passing Health Manpower Legislation making it mandatory for physicians to serve two or more years in under-doctored, largely rural areas," said Dr. Marine.

Data such as Mr. Hammond has collected would suggest another possible less compulsory way of solving the problem. Given students of equal ability, students from smaller communities could be given the edge in acceptance to medical school."

The study was based on information available on 243 white male graduates who gave permission to use their records. The admissions and academic records of these graduates were abstracted and supplementary information was obtained from Physician Reference Listing AMA 1972. The number of women was too small to be able to protect confidentiality.

Among the other findings of the study was a strong relationship between academic performance and selection of specialized (straight) versus general internships. For instance, 89 per cent of those in the top 25 per cent of the class served specialized internships compared with 37 per cent of those in the bottom 25 per cent.

The state where the graduates eventually set up practice was strongly associated with the state of the medical school attended and the original state of residence.

Among the Emory graduates a higher percentage stayed in Georgia (65 per cent) than persons from Florida stayed in Florida (54 per cent) or persons from other states stayed in their respective state (44 per cent).

The activities of Council and its Ad Hoc Committee studying the situation are reviewed.

MAG Develops a Position on the Medicaid Manual and Physician Provider Agreement

EARNEST C. ATKINS, M.D., *Decatur**

On May 12, 1975, the Medicaid Division of the Department of Human Resources issued a Physicians Services Policy and Procedures Manual Draft. This draft contained innumerable objectionable items briefly summarized here in order to give the flavor of its content. It might be of interest to note here that MAG was asked to submit its comments within four days—by May 16.

Medicaid intended to require a physician to show proof of specialty by sending a copy of his board or college certification along with his signed Physician Agreement to Medicaid. If such specialty society or college certification were not presented then, the reimbursement basis for the physician would be that of a general practitioner.

Another section of the law allowed the Medicaid Office to immediately terminate physicians who, in their opinion, were not complying with the regulations issued by DHR. This provision of the Manual offered no due process to the physicians.

A significant chapter dealing with a listing of procedures which required prior approval before they could be provided to patients was noted in the Manual, although in the original version of the Manual they were not listed.

Although for some time the Georgia Medical Care Foundation has been performing both utilization and quality care review for the state's Medicaid Program, the Medicaid Office in its Manual proposed that it should make determinations regarding the quality of services provided to Medicaid patients.

In one of the more offensive sections of the Manual, Medicaid required that in any case in which a patient had other third party coverage, the physician was unable to accept any payment whatsoever from the third party in excess of the amount that was payable by Medicaid.

Perhaps the most ludicrous and most objectionable section proposed by the Department was in the one referred to as the "prudent buyer" concept. Under this section, a physician was required to determine whether or not there was more than one mode of treatment available for caring for a patient, and then he was to provide the least expensive form of treatment.

In dealing with the actual operations of a physician's office, the Medicaid administrators suggested that a physician would be reimbursed only for services that he directly provided with the single exception of injections administered by an R.N. No attempt was made by Medicaid to understand the sort of team concept upon which most physicians' offices function today.

The final affront in this original manuscript was the requirement that a physician sign in advance of providing services an agreement in which he assented to each and every regulation issued by the Department. In signing this agreement, the physician confirmed that he became an agent of the state and would limit his services in accordance with the state's directives.

MAG Comments on Medicaid Manual and Provider Agreement

MAG presented strenuous objections to the issuance of this Medicaid Manual and Provider Agreement. Each physician member of MAG in the state received a letter from the MAG Secretary outlining the major objections which are reviewed above. As the result of these objections, several modifications were made in the Manual by the Department of Human Resources at its meeting in June.

* Secretary of the Medical Association of Georgia, Dr. Atkins is a surgeon whose practice is at 2910 N. Druid Hills Road, Decatur, Ga. 30329.

Since there was an opportunity for the MAG Council to meet and consider the Medicaid Manual and Provider Agreement, the Council reviewed the contents of these documents and reached several conclusions, the most important of which were distributed in an all member mailing in June. The most significant action was as follows:

"MAG advisers its membership not to sign at this time any new Medicaid Agreement but to continue to sign the Agreement (claim form) on an individual patient-by-patient basis as we are now doing, since MAG is attempting to have the Department of Human Resources modify the proposed rules and regulations for physicians treating Medicaid patients in Georgia."

In order to begin negotiations with the Department of Human Resources, Council appointed a special five-man committee composed of J. Dan Bateman, Albany, chairman; Harrison L. Rogers, Jr., Atlanta; W. Dan Jordan, Atlanta; Harvey M. Newman, Gainesville; Beverly B. Sanders, Jr., Macon; Fleming L. Jolley, Atlanta (ex-officio); and Mr. A. R. Jablonowski, MAG Staff.

Ad Hoc Committee Meetings and Discussions

The members of the Ad Hoc Committee which considered the Medicaid Provider Agreement and Manual met on several occasions—during the AMA meeting in Atlantic City, together with the physician representatives of the Department of Human Resources' Board in Atlanta, the committee members themselves together in Macon, and individually with physician members of the Board of Human Resources.

At the conclusion of the last meeting, June 28, 1975, of the Ad Hoc Committee with the physician members of the Board of Human Resources and certain staff members of the Medicaid Division, the group came to a general agreement on certain elements contained within the Policies and Procedures Manual for Physicians as well as the Physician Provider Agreement.

Perhaps most importantly, the Physician Provider Agreement was changed significantly, although not completely eliminated. The significance of the change is as follows: In the original agreement the physician agreed to comply with each rule and regulation issued by the Department and included in the Manual. Under the new Physician Provider Agreement that must be signed, the physician agrees to keep records and to allow access to those records to the Medicaid Department in order to make determinations concerning claims payment as he did in the prior agreement. The second major provision of the new Provider Agreement is that the provider acknowledges the receipt and review of a copy of the Policies and Procedures Manual for Physician Services as amended, but does not sign a statement confirming his adherence to the Medicaid Manual's provisions.

Undoubtedly there will remain significant objection by a great number of our physician members to the very concept of signing such an agreement prior to the provision of services to a segment of our state population, it is the opinion of the state's Attorney General as well as of MAG's legal counsel that such an agreement is required pursuant to federal regulations.

Although there is not sufficient time or space in which to detail the approximately 60 changes which have been made in the Provider Manual, the more significant ones will be pointed out.

Revised Policies and Procedures Manual for Physician Services

The Manual now states that the basic objective of the Georgia Medical Assistance Program is to assure the availability and accessibility of comprehensive and quality care for its eligibile recipients, however, we have added the phrase, *consistent with allocated resources.*

The requirement that the physician submit a signed Provider Agreement in which he agrees to adhere to every provision of the Manual has been removed and the statement inserted reads: "In order to participate, each provider is required to adhere to the following provisions" which then are enumerated.

In a paragraph dealing with the possible solicitation of patients by the physician, a sentence was added which notes that it is not the intent of this paragraph to interfere with the normal pattern of quality of medical care which results in follow-up treatment.

In consideration of a physician terminating his participation in the Medicaid Program, the language of this paragraph was changed to read "A physician has the right to withdraw from the Program at any time. Written notice to the Department of this intent will result in removal of the name of the physician from the vendor file within 30 days."

Under the section dealing with review and audit, a phrase was inserted which allows that quality reviews will be performed under contract by the Georgia Medical Care Foundation.

Unfortunately the section dealing with third party liability *could not* be satisfactorily resolved. It seems that in situations where a Medicaid eligible has third party coverage in addition to Medicaid coverage, the physician cannot legally accept any funds from the third party.

As mentioned earlier, one of the most objectionable sections of the regulations dealt with the so-called prudent buyer concept. To some extent this section was changed. A portion of this statement

now reads, "If two different plans of treatment will, in the attending physician's judgment, meet the need of the recipient, the less expensive treatment should be employed, all other conditions being equal. The concept of the prudent buyer is a broad, guiding principle rather than a rigid regulation. The professional interpretation of this section will be delegated to the appropriate peer review mechanism."

A section which went into some detail as to the freedom of choice of patients and selection of their physicians was changed so that now your committee was able to add the following language: "This section in no way shall restrict the physician's freedom of choice in accepting as patients those eligible for Medicaid."

Considerable difficulty was highlighted by individuals representing group practices in that they would not be allowed to bill under a group practice, but would be required to bill individually by physician. This section was not considered to be negotiable at this time by Medicaid. This section also provides that each physician must bill only for services actually provided by or under his direct supervision. Physicians will not be allowed to bill for services provided by physical therapists, speech therapists, psychologists, physician assistants, etc., unless they are salaried employees of the physician. The common practice of one physician covering for another will not be construed as a violation of this provision. This last sentence as well as the phrase concerning salaried employees were added at the insistence of your committee.

A great deal of confusion apparently exists concerning coverage of patients who are entitled to reimbursement under both Medicaid and Medicare. Your committee was advised by the staff members of the Medicaid Division that in such cases the physician is required to accept assignment from Medicare and must bill Medicaid for its portion of the charges. In other words, it is not possible in such cases for a physician not to accept assignment for Medicare and simply to disregard Medicaid.

Chapter II: Prior Approvals

The most significant actions of the Ad Hoc Committee meeting with the physician members of the Board of Human Resources probably resulted in the changes which will be found in this chapter. These changes, although too numerous to mention here, essentially now allow for the physician to make a decision on whether or not he wishes to request prior approval for certain procedures or whether he is willing to take the risk of retrospective review of those procedures with the possibility that they may be denied or partially disallowed if it is found that they were medically unnecessary or were excessively utilized by the patient. Certain procedures, however, still require prior approval. These include T & A's; removal of keloids; osteopathic manipulative therapy; physical therapy rendered by the physician which exceeds three treatments per week for eight weeks.

A change which may be of some significance should be mentioned. In several sections of Chapter II the original language suggested by the committee used the words reimbursements *may be* limited, whereas the Department has now suggested that the language ought to read reimbursement *is* or reimbursements *are* limited. Another area of disagreement between the last meeting of the committee and a recent decision made by the Medicaid Division concerns the payment for components of laboratory procedures. The Ad Hoc Committee suggested that certain procedures will not be considered for reimbursement without written medical justification and subject to peer review. The staff of the Department suggests that no payment will be made for certain laboratory procedures when they are broken down in a particular manner or when the laboratory procedures exceed a certain number in a specified period of time.

In the section dealing with inpatient hospital care, the committee suggested that adequate documentation must be available to justify performing surgical procedures. The Medicaid staff has responded by indicating that adequate documentation must be presented to justify performing surgical procedures.

At the request of the committee, a rather lengthy section was added to the Manual which details the manner in which the reimbursement will be determined for providers participating in the Medicaid Program.

Council Debates Six Hours

MAG Council met for six hours of discussion on the subject in a special called meeting July 13, 1975. Council now urges members not to sign the Medicaid Provider Agreement.

It is important for the members to understand the conflicting views of MAG and the Department of Human Resources, which have not yet been resolved. The progress made in revising the manual and provider agreement has been reviewed above. The primary area of debate, perhaps, is the Provider Agreement.

MAG is determing the position of the other 49 states, not only in regards to such agreement, but the posture to a provider's manual. We have been told that some 16 states have some type of provider's agreement.

By law we are required to maintain records of

care provided to Medicaid recipients and to make available, when requested, these records to justify charges. MAG has maintained that the individual current Medicaid claim form accomplishes this. However, Medicaid legal counsel maintains that legal action against providers is not enforceable by this current procedure.

Unresolved differences in the interpretations written in the Manual center initially on third party payment procedures. The physician is obligated to determine not only if such exists but to notify Medicaid when it does. Medicaid will be refunded those charges paid by Medicaid in the event a third party does pay. A question not answered satisfactorily is the excess monies which may be paid in customary charges by the third party.

The prudent buyer clause is a problem in its interpretation of provision of the less expensive procedure without alteration of quality of care. The primary charge to all physicians is that of providing highest quality care to all patients.

The Council's Ad Hoc Committee will continue to work with the Department of Human Resources in an effort to resolve those differences that now exist, and the membership will be updated on these developments.

Resolution Adopted

Council adopted the following resolution:

WHEREAS, The Medical Association of Georgia has created an Ad Hoc Committee to Study the Medicaid Manual and Physician's Provider Agreement for the purpose of attempting to modify the interpretation of state and federal regulations, and this committee has diligently pursued this objective and, indeed, has succeeded in changing or modifying some of these interpretations, and

WHEREAS, There are many physicians in Georgia who will of necessity, because of geography and because of their obligation to loyal, ill patients, feel compelled to continue the provision of medical care,

NOW, THEREFORE, BE IT RESOLVED, That the physicians of the State of Georgia be acquainted with the action and changes brought about by our Ad Hoc Committee and the deliberations of this Council, and

BE IT FURTHER RESOLVED, That the physicians of Georgia be directed to follow the dictates of their own consciences or desires regarding compliance with the Medicaid manual and the signing of the provider agreement.

Nevertheless, MAG Council urges that members not sign the provider agreement; and

BE IT FURTHER RESOLVED, That the Medical Association of Georgia express its dissatisfaction with the current intrusion of the bureaucratic methods of government into the practice of medicine as is exemplified by some of the contents and by the method of development of the provider manual and agreement, and

BE IT FURTHER RESOLVED, That the Medical Association of Georgia and the Department of Human Resources jointly continue efforts to resolved objectionable facets of the manual and the provider agreement.

Be assured that MAG will continue to work on behalf of each and every one of you, our members, in our effort to further the negotiations with the Department of Human Resources and make Medicaid a more acceptable program. ■

SYMPOSIUM ON DEATH FEATURES DR. ELISABETH KUBLER-ROSS



A world-renowned authority on death will come to Kennesaw Junior College in Marietta October 20 for "A Day With Dr. Elisabeth Kubler-Ross." Dr. Ross is the author of "On Death and Dying," "Questions and Answers on Death and Dying" and "Death: The Final Stage of Growth."

The schedule calls for opening remarks by Dr. Ross giving a general overview and discussion of her pioneer work from 11 a.m. to noon. Participants will meet in small groups for discussions from noon to 12:30 p.m., then take a break during which books on the subject now available may be viewed, followed by lunch in the college cafeteria.

The afternoon session will begin at 2 p.m., with Dr. Ross discussing, "What Is It Like to Be Dying?" A panel at 3 p.m. will be composed of Dr. Ross, Joseph Barnett, M.D. of Marietta, Dr. Peter Ré and a clergyman.

This symposium is presented by the Interdisciplinary Seminar Committee, Rev. Jim Ramsey, chairperson, of the Cobb County Symposium, through the Cobb County Medical Society, Kennesaw Junior College, Cobb Judicial Circuit Bar Association and Cobb County Ministerial Association. The only charge will be for lunch. For additional information, write the Office of Community Relations, Kennesaw Junior College, Marietta, Ga. 30060, or call the college at (404) 422-8770.

Can Professionals Talk With Each Other?

JONAS ROBITSCHER, J.D., M.D., *Atlanta**

Solutions to today's problems cannot be reached in isolation, the author notes, so interdisciplinary communication is necessary and inevitable.

In a world of specialization, can we communicate across disciplinary boundaries to learn about each other's areas of special competence in order to achieve a unified approach to problems that do not stop at disciplinary boundaries?

Or are we fated to lead fragmented existences where each expert works away in his own field, oblivious to the aims of other disciplines, too busy to participate in a joint attack on problems, unconcerned about the interrelationships of fields of organized knowledge?

Something interesting and ironic has happened in man's long history. He was once among the weakest and most defenseless of animals. Spurred on by his need to survive in a hostile environment, he developed skills—including the communications skill that made it possible to pool knowledge—and he rose to a position of supremacy over all other creatures.

But the same ability to communicate which made it possible to combine knowledge also led to the multiplication of knowledge, to the development of more fields of knowledge than one man could ever encompass and it led to the development of civilizations of incredible complexity. The same communications that originally brought us together have succeeded in recent centuries in separating us. This is our modern reenactment of the story of the Tower of Babel. We say so much to each other—and still have so much left to say—that our sense of isolation deepens. Once again man despairs that his skills can bring order and control to his universe.

Language: The Abstract Tool

Theodore Lidz has described the conditions which led to the leap forward of man from precivilization to civilization and the role of language and communications in that advance. He writes about our ancestors in the trees who developed the apposable thumb, evolved a characteristic of single birth which gave the infant the benefit of the undivided attention of his mother when she jumped from tree to tree, became accustomed to living in groups and giving vocal signals for defense, and acquired a vastly increased brain size. "When for some reason our ancestors returned to live on the ground," Lidz writes,

> . . . the direction of future evolutionary selection had been established. Out of the trees, this ape man must have been highly vulnerable. He had little in the way of physical characteristics to safeguard his existence; no body armor, horns, tusks, claws, or massive strength, special fleetness of foot, or protective coloring. But he was endowed with a brain that, even in its relatively rudimentary form, bestowed new attributes that were worth the sacrifice of other characteristics. He could use tools . . .
>
> The ability to use tools depended upon the evolutionary acquisition of a brain and neuromuscular system capable of exquisite voluntary movements that could be learned. It was a brain that also made possible the fine coordination of movement of lips, tongue, larynx, and facial and respiratory muscles that permitted the acquisition of another tool, the less tangible tool that faded into thin air as its waves spread out in widening circles—the word. Upon the importance of this abstract tool grown into language rested the further evolution of the prohominid into the human—that is, upon the word which permitted protoman to communicate explicitly in order to direct others, and eventually to direct himself by reflective thinking.

In time language grew into a medium of communication capable of conveying the meaning of art and literature, science and medical science, physics and engineering, architecture, commerce, law, philosophy, theology and all the rest of man's knowledge.

During the Renaissance we had a spurt in the

* Henry R. Luce Professor of Law and the Behavioral Sciences, Emory University School of Law, Atlanta, Georgia 30322. Presented at the Ninth Annual Cobb County Symposium, April 19, 1974 at Kennesaw Junior College. The Symposium theme was "The Struggle to Communicate."

flexibility and sophistication of language—we were able to convey more meaning, and language then became an even more useful tool—but the rapid expansion of knowledge left us with more that needed to be communicated. The development of the printing press signaled the start of multiple communications; each of us can now communicate with all the rest of us, and communications has ever since proliferated at an exponentially expanding rate.

The Renaissance Man

At some point we had the phenomenon of the last Renaissance man—the last man able to encompass within himself all the various fields of knowledge of his time, the last man capable of communicating with all his fellow professionals. We have passed the period of the Universal man and reached the period of the specialist who not only has staked out a field but one narrow portion of a field for his special domain, and whose methods and vocabulary have become foreign territory to all other disciplines. The professions dealing with so basic an occupation as farming have multiplied to include biochemistry, physics and agrometeorology, soil science, engineering, botany, crop physiology, animal physiology and nutrition, genetics, entomology, plant and animal pathology, economics and sociology, farming systems and production methods, human nutrition, food processing, applied statistics and operational mathematics. All these are in the curriculum of a program designed to create a well-rounded farmer.

Leonardo da Vinci, Francis Bacon and others have been given the credit for being the last Universal or Renaissance men. In more recent times and in our country, although born too late to encompass all the knowledge of his time, Thomas Jefferson has been considered our closest approximation to this wonder. Jefferson's developed interests included mechanical invention, agriculture, botany, geology, paleontology, medicine, politics, philosophy, literature, architecture, and more, In his autobiography Jefferson gives credit for his scientific interests to his professor at William and Mary, Dr. William Small, whom he describes as "a man profound in most useful branches of science, with a happy talent of communication."

Thomas Jefferson's mastery of many fields of knowledge was summarized nicely when President Kennedy spoke to a collection of American Nobel Prize winners at a White House dinner. He addressed them as "the most extraordinary collection of talent, of human knowledge, that has ever been gathered together at the White House, with the possible exception of when Thomas Jefferson dined alone."

The program for education prescribed by this Universal man for a young Virginia cousin at the University of Edinburgh anxious to become a lawyer, tells us what education a man could hope to achieve in 1786:

A proper foundation in languages and mathematics was needed to support the superstructure of a University education.

He proposed extensive preparation in astronomy, natural philosophy (which we call physics), natural history, anatomy, botany, and chemistry. "No inquisitive mind will be content to be ignorant of any of these branches."

He did not advise concentration in all these fields —"this is more than any genius joined to any length of life is equal to." Instead, he recommended concentration in order to attain eminence in one field, and he recommended particularly natural history, botany, and physics.

"While you are attending these courses you can proceed by yourself in a regular series of historical reading. It would be a waste of time to attend a professor of this. It is to be acquired from books and if you pursue it by yourself, you can accommodate it to your other reading so as to fill up those chasms of time not otherwise appropriated. . . ."

When the sciences have been mastered, advised Jefferson, the study of law should begin. This like history is to be acquired from books, not professors. Jefferson recommended that his young cousin read law in France, so he could be acquiring another language at the same time.

A man who acquired all the knowledge that Jefferson prescribed would fall far short of being a Universal man today. He would lack most of the behavioral sciences—psychology, sociology, anthropology—most of the advanced work in political science—urban planning, community organization—and all the work in statistics, statistical method, biometrics, experimental design, computer programming, and more that are needed to deal with the many facets of modern life.

Since Jefferson's day we have seen an amazing growth of specialization, which still continues, but we are more and more aware that individual specialities do not have the answers to all, or even many, of our problems. We find a need for a systems approach in which each field will not proceed autonomously but in which the effects of movements in various interrelated dynamic fields will be appreciated.

We now point to the monodisciplinarian as being narrowly chauvinistic, unaware that his nuclear power plant may be a source of potential genetic danger, that his pipeline may disturb ecology, that his attempt to achieve full employment may lead to inflation.

Law and Medicine

My particular field of interdisciplinary interest is law and medicine, and more specifically, law and psychiatry. Dr. William Curran, the Frances Glessner Lee Professor of Legal Medicine in the faculties of Medicine and Public Health, Harvard University, in a Commonwealth Fund study, the results of which appeared as "Cross-Professional Education in Law and Medicine: the Promise and the Conflict," deals with the growing practice of attaining dual degrees, in law and in medicine, and how dual degree people fare in a largely one degree world.

Curran started out with the premise that doctors and lawyers have a need for interdisciplinary cooperation.

> Among the most influential professional groups in the United States are the physicians and the lawyers. There are many areas of cooperation between them and many areas of rather open conflict. Malpractice suits and personal injury actions are misunderstood and resented by many physicians. Lawyers do not like the unwillingness of many physicians to testify in court. Recent advances in medical science have challenged both professions to find new means of accommodation.

Curran did not list, but he could have, a number of other areas beside malpractice and court testimony where lawyers and physicians interrelate. Abortion, sterilization, and birth control; genetic manipulation; euthanasia and the "right to die"; environmental pollution; standards of nourishment; governmental control of drugs and medical devices; protection of experimental subjects; confidentiality and privilege; medical and psychiatric health care delivery; narcotics, alcohol, murder, violence, and criminal responsibility; venereal disease and control of other communicable diseases; the legal enforcement of sexual morality; juvenile delinquency; the provision of medical and psychiatric care in prisons; the definition of death; transplantation of organs; cyrogenics; psychosurgery; the protection of the rights of the mentally disabled; the problem of informed consent; eugenic sterilization; protection of the rights of the mentally retarded—all these are topics where both the lawyer and the physician may have an important input.

Curran decided to study one aspect of the relationship between the professions which he felt had gone largely unnoticed by either group, the growing number of persons in the United States who had professional degrees in both law and medicine. He found 203 people in the United States who had both degrees, in addition to a number who were dual degree holders in dentistry-law; hospital administration-law; public health-law; and pharmacy-law.

One misconception he discovered about this group was that an M.D.-LL.B. must be making a huge income, since his unique talents would be in such great demand. Says Curran, "We found little evidence to support this impression." Among the survey group were high income people, but nearly all of these were engaged in fulltime medical practice in a speciality where such an income could normally be expected.

Most of the respondents indicated that even with a cross-professional education one must choose a single career line in order to succeed, or even to earn an adequate living. Some of the respondents' comments were:

"Opportunities are limited. . . . There is no crying need for the amphibian."

"There is a lack in our society of any specific niche for this type of individual."

"Perhaps there are areas of combined interest where the M.D.-LL.B. is, in fact, needed—as yet I haven't found them."

A minority of the respondents did find the combination of disciplines useful—in personal injury law practice, forensic pathology, forensic psychiatry, work with insurance companies and drug firms, and teaching—although only six of the group were in full-time academic work.

Over one-third of the respondents reported they had experienced negative reactions from their colleagues in law or medicine because of their possession of dual degrees.

Specialize and Cooperate

Curran's conclusion was that with the exception of my own field, forensic psychiatry, no medical speciality requires any significant degree of formal legal education, and an abbreviated law course, not looking toward a degree, not taking up more than a year, would be sufficient for most interdisciplinary purposes. He leaves us with the implication that rather than one person combining two disciplines it is better to have two people representing separate disciplines who have the ability to work well with each other. Curran states: "Our survey revealed no medical areas where a full, professional legal degree was deemed necessary or even highly desirable by any appreciable number of respondents."

An example of interdisciplinary communication that Professor Curran would highly approve, based fortuitously on the accident of twinship, can be

found in the careers of Alfred and Blair Sadler, who are identical twins. Blair graduated from the University of Pennsylvania Law School, Alfred from the University of Pennsylvania Medical School.

Engaged in fellowships in Washington, they worked together on the Uniform Anatomical Gifts Act and on the related question, involved in organ transplant cases, a modern definition of death. They went from this to joint directorship of the Trauma Project at Yale University, a study of the legal and medical approach to accident victims. They are now each, or perhaps jointly, Assistant Vice President of the Robert Wood Johnson Foundation, the largest potential source of private philanthropic support for medicine.

But being one of a pair of twins is not always the solution to the problem of interdisciplinary communication and cooperation. Professor Curran's suggestion, that for a proper understanding of interdisciplinary fields one person should secure a complete professional background in a major field and an incomplete one in a minor field, and that most interdisciplinary projects be conducted by people from various fields coming together for varying periods of time does make sense, but I think he underrates the advantages of a combination of disciplines in one person.

Excess Politeness

The objection to working together can be an excess of politeness. A law professor and a psychiatrist join together to teach legal psychiatry. Each is happy that in a hostile world he has found someone outside his discipline who will be a collaborator. Their gratitude to each other obscures differences. "I am sure you have much to offer," they tell each other. On the classroom lecture platform each outlines what his field has to contribute. They are convinced that if they learn to speak a common language, take the time to understand mutual concerns, they will make progress in clearing up all common problems.

As solicitous of each other as Alphonse and Gaston, they can share the same platform without ever focusing on some of the basic problems in legal psychiatry. Problems which did not appear in the earlier collaborative books on the subject only appeared when one person—a Thomas Szasz, a Morton Birnbaum—attempted to synthesize opposing points of view within himself and concluded that something more than politeness and a common semantic approach was needed—that law and psychiatry have individual aims which can only be reconciled by hammering out new positions. The earlier collaborationist literature is full of promises that can be fulfilled if only the courts would make more use of psychiatric services; it was not until Thomas Szasz attempted his own synthesis that he understood, and could point out, that the psychiatrist working for the court is not fulfilling a traditional psychiatric role because he does not owe primary allegiance to his patient, and he sometimes penalizes a subject for lack of cooperation or refusal to discuss his offenses —stigmatizes him as negativistic or sociopathic— without understanding that he is being seen by the subject, quite correctly, as an agent of the court, a role far different from a treating physician.

Some of the problems in legal psychiatry which were overlooked during the era of initial and polite interdisciplinary communication were:

Sexual offenders under the sanction of special sexual psychopath and defective delinquency acts were denied due process of law when charged with criminal offenses and instead were committed to mental hospitals where they could be held indefinitely.

People who were too mentally ill to stand trial were also hospitalized for long periods of time in special hospitals for the criminally insane—until they recovered their sanity—in spite of the possibility that they might not be guilty of the crime and perhaps would be more appropriately housed in a regular, not a prison-type, mental hospital. Lawyers and psychiatrists had both abdicated responsibility for these patients—the psychiatrist took physical responsibility but did not guard his patient's legal rights. Lawyers were all too ready to abdicate responsibility for this troublesome kind of defendent and were happy to hand him over to the psychiatrist. The psychiatrist was usually not aware that the law wants all but the most disturbed defendents to stand trial and that many of his patients were being held in excess of legal authorization.

Another example: Judges and probation officials uncritically accepted estimates of future dangerousness from psychiatrists—glad to have a prediction concerning the likelihood that crimes would be committed again in the future, without an awareness that there was little scientific basis, and most psychiatrists would not claim such basis, for believing that these predictions were more accurate than predictions made by a layman.

In all these instances, there was interdisciplinary communication, but of a counter-productive kind. The lawyer or judge was saying in each case, "Since you as a psychiatrist have more expertise in dealing with the abnormal offender than we have, let us turn the problem over to you," and the psychiatrist, flattered to be given all this responsibility, was accepting the problem without being aware that the legal rights of the individual were being neglected. This is interdisciplinary miscommunication. It will continue as long as the two disciplines which are

communicating with each other do not take time to thoroughly understand each other's areas of usefulness and each other's limitations. The cross-disciplinary individual who has tried to master two fields can often be a useful person in pointing out the real problems that lurk below the surface appearance of cooperation.

Dealing With Ultimate Questions

Several years ago The Henry Luce Foundation decided to support a number of interdisciplinary chairs at colleges and universities. In 1955 Henry Luce had written:

> I speculate that a consequence of the abundance which now is—and even more of a superabundance to come—may be that men and women will experience a more direct confrontation with the ultimate questions concerning the meaning of human life and its purpose. . . .
>
> What, then, is the purpose of life? Trips to the moon will not abate the naked urgency of this question: they will only confront man all the more with the meaning of his existence in the whole light-year cosmos. The confrontation is predictable; whether men in 1980 will have the grace and intellectuality to cope with it is unpredictable.

In the interests of orienting itself toward programs that were innovative, integrative, and interdisciplinary—and eventually to stimulate concern with ultimate questions—The Henry Luce Foundation funded a series of interdisciplinary chairs to promote "freer movement across academic lines and fresher insights into questions of human values." The first chairs were at Cornell University, in science and society; at Hampshire College, in law studies for non-professional students; and New York University, in urban values. The next group of four —among which was my chair at Emory University in law and the behavioral sciences—included Dartmouth College, environmental studies and policy; The Fletcher School of Law and Diplomacy at Tufts University, civilization and foreign affairs; and Princeton University, political jurisprudence. More recently there have been additions: Harvard University, film study; The California Institute of Technology, law and social change in the technological society; The Massachusetts Institute of Technology, environment and public policy; and Mount Holyoke College, cosmology, which deals with the purpose of the universe and the place of man in the universe.

But all interdisciplinary fields, whether they seem as practically oriented as environmental studies or law and the behavioral sciences, or as philosophically oriented as cosmology, must deal with ultimate questions. The fate of a mentally subnormal, emotionally deprived individual charged with a crime and faced with a criminal sentence raises questions about free will and determinism, conscious and unconscious motivation, the responsibility of society for its members, the definition of "help," the relative roles of punishment and rehabilitation, the division of responsibility among educators, penologists, behavioral scientists, and jurists. None of these questions are easy and all are tied into larger concepts of meaning and values.

Working in an interdisciplinary field, it is easy to see interests in conflict, sometimes seemingly irreconcilable, and how much of what we do represents an uneasy compromise between the values of competing disciplines. Working in a monodisciplinary field, it is easy to oversimplify and to feel that some one answer—better prisons or better parenting, a better distribution of wealth or a better inculcation of moral values, more psychiatric services in the community or more equal administration of justice—will resolve a complicated problem.

Multiple Point of View

The task, then, for interdisciplinary people is to persuade monodisciplinary people to join with them in looking at problems from a multiple point of view. How successful can we be in talking across interdisciplinary lines—lawyers talking to physicians, theologians to economists, political scientists to educators, psychologists to penologists? In the absence of the abilities of a Thomas Jefferson, how many fields can we consider and attempt to integrate? The advances in biomedical technology particularly highlight the interrelationship of disciplines; on the subject of contraception or population control or the right to life of a genetically malformed infant, can we get a meaningful colloquium that includes the doctor, the minister, the psychologist or psychiatrist, the economist, the political scientist, the geneticist, the lawyer?

Can professionals talk with each other? Professionals can talk with each other—but with difficulty. I have grouped the reasons for the difficulty of communications under some main headings: Logistical, Psychological, and Practical.

Limits of Time

By *Logistical* I refer to the limits on our time, energy, and the financial limitations that keep us from becoming more fluent in interdisciplinary communication. Time is a chief limiting factor. Our fields of knowledge have grown to be so multiple

and each field has grown so large that encompassing various fields becomes increasingly difficult. The expert who studies law and environmental problems feels the lack of sociology, and if he masters this field then he wishes to learn statistical methods or computer technology. The number of combinations of disciplines and the relatedness of disciplines can lead to megalomanic efforts to encompass so much that nothing can be truly related and understood. The practicalities must be kept in mind. A sentencing judge in a juvenile court could benefit from, in addition to his knowledge of law, a knowledge of child psychology and child development, sociology, the administration of criminal justice, penology, and education—but we know that juvenile court judges will not be such universal experts. They will be so burdened with heavy caseloads, and have so many professional and civic obligations that they will not have time even to consult the other experts who might be helpful. If they do find money to hire an expert for their court—a child psychologist, for example—they may be so pleased to be relieved of a share of the responsibility that they may end up abdicating responsibility and turning over too large a share of decision-making authority.

One answer to the logistic problem is to separate the dross from the gold in our fields, to recognize that a good deal of the journal literature in a number of disciplines—I refer particularly to the behavioral sciences—represents the reaction of the professional to the edict of "publish or perish" or is his method of obtaining governmental funds by devising new projects and new approaches that do not necessarily have any more to offer than older approaches—except for the salability conferred by novelty. Our thirst for self-glorification and novelty needs to be restrained. We need to practice self-denial, to ask if this publication is necessary? If this project is necessary? I am not entirely hopeful that we can exercise this self-restraint, but in its absence I am sure we will overcommunicate ourselves to death—drown in a sea of useless communication unaware that interspersed through it is life-supporting information we cannot isolate and use.

I have said that time is a limiting factor—and this combined with disinterest works against communication. Several years ago some behavioral scientists in Philadelphia became convinced that conditions in the Philadelphia prison were so insufferable that an explosion must surely occur. They planned a dinner meeting to focus discussion on this situation and made a special effort to secure the attendance of judges. Only two judges attended the dinner, and after the meal and before the discussion they politely excused themselves on the ground of a previous engagement. About three weeks later the predictable riot erupted.

Sometimes the limitation of time leads to a less dramatic kind of neglect that may be equally harmful. The two groups most interested in getting medical ethics into the medical school curriculum, so that future doctors can ponder the application of new medical technologies, are lawyers concerned with informed consent and theologians concerned with moral values; they are met with the conviction on the part of those who formulate medical school curriculums that as important as biomedical ethics may be, time cannot be spared from cardiology, communicable diseases, and neuroanatomy to make way for material on the right to die and the right to live. Having others recognize our interdisciplinary concerns as important remains an uphill struggle.

Different Temperaments

In addition to these logistic limitations—the availability of time, personnel, money, energy—there are *Psychological* barriers that impede communication. In *Pursuit of Agreement: Psychiatry and the Law*, I described some of the temperamental characteristics of lawyers and psychiatrists. The qualities that make one a good practitioner in his own field—the logical ability of the lawyer, the empathic sensitivity of the psychiatrist—may make one unsympathetic to the approach of the other. Lawyers see the psychiatrist who wishes to get at a dynamic understanding of the defendent as trying to coddle him. Psychiatrists see the lawyer who wishes to provide equal justice and a consistent, anticipatable system as being rigid or inflexible.

Lawyers like precedents. One of the reasons they chose law was to establish rules and guidelines in a disorderly world. Psychiatrists like exceptions. They see a defendent not as a member of a class but as a person with individual problems. The qualities which led to the choice of a particular profession may put one out of sympathy with members of another profession.

Lack of Motivation

But perhaps the factor that works most against interdisciplinary communication has to do with motivation and is both psychological and *Practical*. Until recently there were grave injustices, the result of a lack of procedural due process, in the field of legal psychiatry. Psychiatrists were not disposed to study these injustices, because they were its beneficiaries—the law gave them much responsibility and did not question the treatment they offered. Lawyers were not interested because there was little practical application for their knowledge—courts were not in-

(Continued on page 310)

A PATIENT'S NURSE IS HIS BEST FRIEND

Greetings delivered to the Nursing School Graduates of the Piedmont Hospital by John E. Skandalakis, M.D., President of the Staff, June 6, 1975. Dr. Skandalakis is in practice at 35 Collier Road, N.W., Suite 315, Atlanta, Ga. 30309.

There is no question in my mind that a patient's best friend is his nurse. The nurse will stay with the patient when his family has gone home. The nurse will make the patient feel at home when he is friendless and homeless. One of my ancestors, Euripides, stated "It's better to be sick than to nurse the sick. Sickness is a single trouble for the sufferers: but nursing means vexation of the mind and hard work for the hands, besides." How right this great tragedian was! And we witness this every week in our hospital where durability of body and presence of mind are so essential for good patient care and many many times, indeed, life saving measures.

The nurse cares equally for the poor or rich, the young or old, the famous or unknown, the ugly or beautiful. This reminds me of the story told of Ambroise Paré when King Charles IX told him to give him better care than he had given to the poor. The great French surgeon answered, "I care for the poor as much as I care for kings."

And when death takes the patient in its embrace and his body is still warm on the hospital bed, the nurse will clean the bed, take care of the body, and take care of the family with a sad smile . . . a smile full of comfort and sympathy.

However, I want to emphasize something which I have recently observed. Many times nurses spend too much time with paper work. Unfortunately, our changing era with all the medico-legal problems and agonies demands this paper work. We all believe that our primary responsibility is the patient. The great teacher of medicine, Osler, said "observe, record, tabulate, communicate." This was written in 1919 and still stands today. However, I would say: treat the patient first and observe. Record and communicate your observations to the doctor. You don't know how grateful we are for your advice and suggestions. Sometimes our superficial egos do not show our appreciation, but be sure it is there.

I think that I have talked too much. I had better stop. Some of you will stay here in Georgia, while others will go—God only knows where. But please permit me to say to you an Irish wish that I love very much:

May the road rise up to meet you,
May the wind always be at your back.
May the sun always shine upon your face,
And the rains fall soft upon your fields.
And until we meet again. . . .
May God hold you in the palm of his hand.



Pro-Banthine®
brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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clined to help the mentally disabled so a study of the problems had no immediate utility.

When courts began to define new rights for the mentally disabled, to allow class actions, to forge new precedents in cases involving standards for commitment, the right to treatment for involuntary patients in state hospitals, the right of a committed patient to be held in the least restrictive alternative, the right to be compensated for work done while a patient in the hospital, lawyers found there was a practical application to legal psychiatry. It has become a much more popular field for lawyers. Most psychiatrists, however, in training or trained for private practice psychiatry, still see this as someone else's problem—the problem of the state, the director of the state's division of mental health, the doctor who works in the state hospital—not for themselves. They do not want to put in the time and effort that would bring them up-to-date with new legal developments in a field they do not yet recognize as "their field."

Another great bar to interdisciplinary cooperation and communication is territoriality. If we wish to build a bridge between law and psychiatry, or medicine and ethics, or literature and psychoanalysis, we need a base of support for this interloper into an arrangement of established disciplines. Both disciplines involved will pay lip service to the need for a bridge, but neither will sacrifice itself, devote part of its own budget, some of its own personnel, to support a new interdisciplinary hybrid that has as one of its purposes the objective and critical viewing of the field which is being asked for support.

Even when there are declarations of interest and good will, there is always a higher priority. Once again, lip service is paid to the idea of interdisciplinary cooperation, but financial support and curriculum time are not available. And when a new breed of interested and interesting young student arrives, anxious to combine and synthesize old disciplines into something new, the edict is that credits earned in one school cannot be transferred to another, that practical in-the-field experience will not be recognized as worthy of college credits, that scheduling problems prevent students from one school in enrolling in another.

Fortunately, the new student will not be stopped. Rightly or wrongly, he sees interdisciplinary synthesis as an answer to problems or, at the very minimum, an opportunity to ask more searching questions. Students are risking career security by training for interdisciplinary positions that as yet have no firm support. In the process of combining disciplines they are defining new fields and, hopefully, new opportunities.

Can the professions communicate with each other? Yes, with difficulty. But the older monodisciplinarian is being crowded by a new group of younger professionals who see more need for cross interdisciplinary lines and who invest more in talking to other professionals. And colleges and universities are giving some attention—not as much as is needed but still an appreciable quantity—to communications across disciplinary lines. We see increasingly that we cannot work out solutions to complicated problems in isolation, and we do communicate more and more with each other in spite of some rebuffs and considerable disinterest.

The interdisciplinarian is on the cutting edge, advancing into new areas of complexity, and in addition to the satisfaction he has in conversing with himself he is beginning to find that others share with him the excitement of synthesizing and resynthesizing old disciplines into something rich and strange. ■

KNOWLEDGE ON ALCOHOLISM SHARED AT SEMINAR

A Georgia Physicians Seminar on Alcoholism, designed to provide an opportunity for sharing knowledge and experiences in alcoholism with colleagues who have had extensive experience in the field, is planned for September 28, 1975 at the School for Continuing Education in Athens.

The program is sponsored by the Alcohol and Drug Section of the Division of Mental Health, Department of Human Resources in collaboration with the Medical Association of Georgia and the Georgia Hospital Association.

The seminar will cover the perspectives of treatment of alcoholism for all settings, including private practice, institutions and community programs. Dr. Jack Morgan of the Alcohol and Drug Dependency Clinic of Tennessee Psychiatric Hospital and Institute in Memphis will speak on "Phases of Alcoholism and Treatment Methodology." After the lunch break, Dr. James Garber, an internist from Rochester, Minnesota, will explain the "Internist Role in Treatment of the Alcoholic." A reactor panel closing the symposium will be made up of Dr. John Griffin, Emory, Dr. Samuel Heaton, District Health Officer from Dublin; Dr. Kenneth Shoemaker, Director of the Central DeKalb Mental Health Center; and Dr. Henry Yost of the Mental Health Regional Hospital at Augusta.

Applications for attendance should be returned to the Alcohol and Drug Section by September 15. Expenses such as travel, meals and lodging (if distance from Atlanta requires overnight lodging) will be reimbursed by the Center of Continuing Education.

A pertinent question is raised as to whether changing the existing health care delivery system will effect improvement.

Health Field Concept in Georgia

ROLAND J. KNOBEL, Ph.D., MAX G. HOLLAND, Ph.D., JAMES W. ALLEY, M.D., *and* MARK HARBISON, *Atlanta**

THERE IS MUCH discussion in the United States today over the adequacy of the *health care system.* A growing consumer consensus seems to be demanding change. Of widespread concern are rising health care costs, maldistribution of health resources and the quality of total health system outputs. Almost obscured in the debate is the basic question of whether changing the existing health care delivery system will effect improvement.

The World Health Organization has suggested an alternative health goal. By W.H.O. standards, health is "a state of complete physical, mental and social well being, and not merely the absence of disease and infirmity."[1] Such a concept, as Olympian as it may seem, implies a need to look beyond improving the health care delivery system to achieve basic goals of health and well being.

The Canadian Plan

The Canadian government has adopted this broader health perspective. It proposes the *Health Field Concept* as a method for considering a broader range of elements which contribute to health and well being.[2] This concept recognizes that the health of a community is not only influenced by the *health system,* but also by *human biology,* the *environment,* and the *life styles* of its citizens. Approaching health problems from this perspective holds promise of being more rational and integrative in that it provides a mechanism for dealing with both the prevention and cure of a disease. More important, it gives equal emphasis to factors which constructively promote health and well being as to those that attempt to reconstitute health once it has been lost.

* Dr. Knobel is a professor of health administration at Georgia State University, and his colleague, Dr. Holland is an associate professor of management. Dr. Alley serves as director of the Division of Physical Health for the Georgia Department of Human Resources. Mr. Harbison is the East Health District Director of Environmental Sanitation and serves as chairman of the Community Health Task Force of the DHR. Drs. Knobel and Holland are consultants to this task force. For reprints, contact Dr. Knobel, at the Institute of Health Administration, School of Business Administration, Georgia State University, Atlanta, Ga. 30303.

TABLE 1
PRIMARY CAUSES OF MORTALITY
GEORGIA 1973

	% of Total
Coronary heart disease	29.3
Cancer	14.9
Hypertension and stroke	14.6
Accidents	8.0
Chronic obstructive pulmonary diseases	6.5
Suicides and homicides	3.6

Source: Georgia Department of Human Resources, 1973.

Morbidity and Mortality in Georgia

It is commonly recognized that a healthy population is essential to continued prosperity and progress in the State of Georgia. The involvement of both health care providers and the general population in improving health status is essential if this goal is to be achieved. The causes of mortality and morbidity in Georgia must be identified and the relative importance of contributing factors determined.

The *Killers and Cripplers Program* of the Department of Human Resources has been helpful in identifying the primary causes of death and disability in the state.[3] The most prominent of these are presented in Table 1. Although many of the factors contributing to the incidence of these killers and cripplers are degenerative and related to the aging process, others are related to self-imposed risks which result in premature mortality and avoidable morbidity.

This Division of Physical Health Program identifies major health problems by geographic area, race, sex, and age. These organized health data make it easier to develop programs for improving the health of special target populations.

There is a need, however, for more and comprehensive data, capable of indicating health trends. A method must be designed to collect information from the numerous private professionals and the individual hospitals around the state. The data from public health sources must be restructured to make them compatible with a comprehensive health data base.

Good data are fundamental to the development of a health care strategy aimed at the diversion of disease patterns in Georgia. In recognizing that much of the death and illness can be avoided, it seems appropriate to focus attention on the major killing and crippling problems in Georgia through the use of the Health Field Concept.

The Concept Summarized

The Health Field Concept provides a framework for identifying the elements associated with levels of health. Without such a framework, it has been difficult to communicate among all parties who have program efforts directed toward improved health. The health field concept, as adopted by the Canadian Government, embraces four broad elements: Human Biology, Environment, Life Style, and Health Care Organization.[2]

Human Biology includes the aspects of health, both physical and mental, which are developed within the human body as a result of organic makeup, and basic biology.[2 (p. 31)] It contributes to chronic diseases (such as arthritis, diabetes) as well as other conditions (genetic disorders, congenital malformations, and mental retardation).[2 (p. 32)] It is associated with genetics, aging, and the many complex internal systems of the human body.

Environment represents those things which are external to the human body over which the individual has little or no control (especially in the short-run). These elements involve the physical environment, the social environment, and the economic environment to which the individual is exposed.[2]

Life Style consists of the aggregated decisions of an individual which affect health and over which the individual has some control.[2] Decisions can positively or negatively affect health status. Decisions which have a negative effect on health create self-imposed risks which can result in premature illness or death. On the other hand, life style decisions which have a positive effect can improve health and well being throughout an individual's life span.

Health Care Organization includes all resources (public and private, physical, mental, and environmental) which provide health care. This element is often referred to as the *health care system*.[2] The Canadians have concluded that while many causes of illness are rooted in human biology, life style and environment, the major emphasis of health resources has traditionally been on crisis or acute health care needs. The system's principal thrust has been generally directed toward treating individuals after they become ill rather than preventing illnesses from occurring.[2]

Applying the Concept in Georgia

A Community Health Task Force was recently established in the state's Division of Physical Health. Participants include physicians, nurses, environmentalists and epidemiologists. This task force was charged with analyzing Georgia's health problems and determining how health efforts should be redirected to reduce mortality and morbidity in Georgia. It has adopted the Health Field Concept as a working methodology.

The Task Force members agreed:

a) that the traditional approach, which concentrates on adjustments in the health care system, does not get at the root causes of disease and death;

b) its multidisciplinary representation recognizes the impacts of environment and consumer life styles on health problems;

c) the Health Field Concept provides a method to logically analyze risk factors contributing to illness and death and the feasibility of attempting to reduce risk factors.

As a first step, the Task Force is applying the Health Field Concept to the major diseases in Georgia. Each of these health problems is being analyzed to (1) identify the primary contributing factors and (2) determine how these factors relate to the Health Field components (human biology, environment, life style, and the health care organization). As a second step, the Task Force is expanding on the Health Field Concept by incorporating systems analysis techniques in arriving at potential programs for diverting disease patterns.

The Task Force recognizes the importance of involving other health professionals in its deliberations. Eight groups were established for the analysis of the primary health problems in Georgia.

These groups have been expanded to include members from the private medical sector and other health professions, program specialists from the Department of Human Resources, and various other organizations with interests in health.

The support of all these groups is essential if a balance between health maintenance and therapeutic care is to be achieved. Physicians, nurses and other health professionals must understand the concept and become involved with program development and

implementation for the program to succeed. Equally important is the involvement of public and independent health agencies.

Development of the Program

The Task Force is attempting to relate the risk factors of a disease or problem area to Health Field Components in a systematic and logical manner. This provides a tool for analysis of potential programs as well as for understanding some of the interactions among factors and programs. In addition, the methodology provides a mechanism to visualize how certain risk factors affect various disease or problem entities.

Through synthesis of these factors, programs with the most potential for reducing or eliminating the target disease can be determined. These programs will be analyzed in light of the real world constraints that would inhibit success. These constraints include restrictive legislation, professional and social dogma, and economic considerations. For example, marked reduction in cigarette smoking, which would remove one of the main contributors to heart disease, will also have significant impact on the agricultural economy of Georgia, where tobacco is a major cash crop.

Another element in the development of disease diverting programs requires the identification of existing programs which focus on the reduction or elimination of the disease entity. Existing and potential programs will be analyzed for gaps and overlaps.

Through this process, logical additions or modifications to existing programs, and requirements to initiate new programs will be determined. At that time, the potential programs for all diseases will be considered in aggregate. This will reveal programs which have multi-impact on a number of diseases, as in the case of hypertension control which effects stroke, heart and kidney diseases. Thus the programs which hold promise of having the greatest combined impact on the health status of Georgians can be determined.

Program ideas, whether designed to address biological factors, environmental factors, life style factors or the health care system will then be converted into operational specifics, described in terms that can be understood by consumers, legislators and health professionals. It is recognized that the health delivery system is essential to the maintenance of a healthy population. The value in adopting the Health Field Concept is to bring about an awareness for looking at health problems from a comprehensive perspective.

Summary

The Health Field Concept takes a systems point of view to health problems which is long overdue. It requires a new way of thinking and it is well documented that change is never an easy or rapid process.

The changes in thinking are numerous. It is expected, that, as in Canada, the greatest payoffs are likely to derive from programs which change the life styles of Georgia citizens; thereby improving their health status and general well being. This will call for added support to programs aimed at inhibiting risk factors that contribute to Georgia health problems. Many of these risks are self imposed, which gives hope that some modification in life style will substantially improve health status. There is little reason to believe that the nature of the existing health system will be changed in the short run. In the long run, however, demands on the health system are likely to change. There will be an increased emphasis on the part of provider and consumer alike toward the maintenance of a healthy population. ■

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Review of County Medical Society Duties and Responsibilities

THE RECENT CHANGE in elected leadership of the Association presents a logical opportunity to review obligations and responsibilities of both individuals and county medical societies to MAG. Problems continue to arise regarding the proper filing of applications, the timely submission of dues money to the Association and the improper maintenance of county society constitutions and bylaws.

Listed below are items from the MAG Constitution and Bylaws that relate to these duties and responsibilities.

COUNTY SOCIETY ORGANIZATION

Charters

Component county societies are chartered by the Medical Association of Georgia. Collectively, the component societies form the MAG.

Charters, outlining the duties and responsibilities of the county society, should be kept by the county society secretary and a copy should also be on file at MAG headquarters.

Duties

Each society is required to meet at least four times per year and *must* elect officers and delegates before February 1. This information *must* be transmitted to MAG headquarters, also prior to February 1.

All county medical societies must develop and maintain constitutions and bylaws that are not in conflict with those of MAG. A copy of these documents should be on file at MAG headquarters.

Delegates

Representation in the MAG House of Delegates is based on one delegate and one alternate for each 25 county society members or fraction thereof who are members of MAG. The number of delegates is determined by the number of active dues paying members and Life (dues exempt) members as of December 31 of the preceding year. Notification of properly elected delegates and alternates must be made to MAG headquarters by February 1.

In order to serve as a delegate or alternate a member must have been a member in good standing in MAG for the *three years* preceding his election. Elected delegates and alternates who do not meet this important qualification cannot be seated in the House. Also, a delegate's dues *must* be paid prior to Annual Session in order for them to be seated in the House.

Dues and Assessments

Dues are established by the House of Delegates upon recommendation of Council.

Prior to October 1 of a particular year county medical society secretaries are required to certify to the secretary of MAG the names of members of the society, their *correct* mailing addresses and the amount of dues and assessments for the next calendar year. This bylaws' requirement is essential for the orderly administration of Association membership business.

Members' dues must be submitted by April 1. If not submitted by this date the member will be suspended along with all member services until *all* dues have been paid.

It is most important that *all* counties *not* on MAG central billing report dues collections as soon as they are received.

Any physician, duly qualified, who wishes to transfer membership from another state to MAG may do so without payment of MAG dues for the year in which he transfers. If an MAG member moves from one county to another, he should advise the Association of this status change and current address.

Dues Exempt Membership

The one dues exempt classification that is most often misunderstood is that of the life membership.

In order to qualify in this category a member must have reached his 70th birthday and have completed 25 years continuous active membership in MAG. A member may also qualify by being a member of MAG for 10 years with the balance being served in another state association.

Life memberships have caused confusion primarily because some county society requirements are different from MAG's. This category of membership *must* be certified through the Association to insure eligibility.

All members, particularly those in leadership positions, should acquaint themselves with the various sections of the MAG Constitution and Bylaws. ■

A Delegate Reviews the AMA Convention

THE JUNE MEETING OF AMA in Atlantic City was a momentous one in the length of the House of Delegates (20½ hours in four days), the volume of reports (which must have weighed six or seven pounds!), the good attendance of delegates (249 seated of 251 elected!) and the terrible accommodations in our ancient hotel, where the water was ice cold every morning at 6:30 as we tried to shave. This meeting was dominated by the feeling that the physicians of our country are worried sick about the problems facing American medicine today and the delegates responded to their constituency by not side-stepping the issues presented. They "took the bull by the horns" and agreed that if the AMA is to speak for 175,000 physicians then it must be as strong as possible.

Leadership Faces Financial Crisis

As reported elsewhere in this JMAG, new leadership has been elected in the AMA. I feel that a striking change in this leadership has occurred in the past few years. This has included election to the Board of Trustees of new members, each of whom assured the Georgia delegation in caucus of his intention to see that the AMA does a better job for its members and their patients. The performance of the AMA during the past six months when abruptly faced with a financial disaster reflects credit on the elected officials and full time staff, and I believe is the main reason for the House action on dues which we increased to $250 per year starting January 1, 1976.

Every delegate was aware of the financial plight of the AMA, starting in 1970 when the House of Delegates refused to accept a sizable dues increase. Each year since that time (except 1972) we've had a deficit, culminating in December 1974 with the AMA having to borrow $3 million to pay current obligations. As you know, the House of Delegates at that time agreed to a $60

Listed below are the dates and locations of future AMA meetings. You are encouraged to make plans now to attend.

AMA MEETINGS

Annual:

1976—Dallas, June 26-July 1
1977—San Francisco, June 18-23
1978—Chicago, June 17-22
1979—New York, June 23-28
1980—Las Vegas, June 21-26
1981—San Francisco, no date set
1982—Dallas, June 19-24 (tentative date)

Clinical:

1975—Honolulu, November 30-December 3
1976—Philadelphia, December 4-7

assessment to "tide us over" and directed (1) a special committee of the House to review our entire operation with emphasis on frugality and a "no frills" recommendations; and (2) an austerity program in the operation of AMA including employee reductions, cancellation of committee expenditures and other specific actions.

The House of Delegates saw the urgent need for a strong AMA. The delegates heard detailed and clear reports, first from the special committee of the House, then from our elected Board of Trustees and finally from the staff in the Report of the Executive Vice-President. We felt that this group was in fact responsive to the problems of physicians and patients and was dedicated to their solution. Our response to all of this was to pledge the financial resources to get the job done. We were impressed by the capability, sincerity and dedication of this group of men and urge your support.

This convention also addressed multiple other problems and made known its intention to press for remedies in court, the Congress, the offices of HEW and with any other organization whether private or governmental. The JCAH (Joint Commission on Accreditation of Hospitals) came under special fire for such problems as its regulations concerning small rural hospitals or those requiring totally unjustified medical audit "projects." The JCAH was asked to strive for a single inspection of a hospital and its medical staff activities each year and was further asked for an opportunity to review proposed regulations before they are implemented. The commission also was asked to review carefully its decisions concerning hospitals and their relations with their medical staffs.

The issue of National Health Insurance along with many other legislative issues, such as the Health Manpower Bill, were included in the agenda. Such diverse items as our objection to being called "providers" instead of physicians, our approval of Senate Bill 410 which removed restrictions on outside income to $2500 for the person over 65 years receiving Social Security benefits or the misuse of the Federal Register in carrying out directives of Congress by various levels of bureaucrats were all addressed by the House. Problems related to the FDA (Food and Drug Administration), specifically the language of package inserts, their timely release of new products and the use of generic drugs were faced and solutions formulated.

Dealing With Education, Malpractice

Many reports and lengthly discussions were assimilated concerning all facets of education. The problems of foreign medical graduates as well as U.S. citizens attending foreign medical schools were addressed along with residency requirements for physicians and the training and utilization of paramedical personnel. Relationships between the medical student and resident and either their educational institutions or hospitals were thoroughly probed and solutions proposed.

The entire scope of the malpractice problem was studied with the remedies for each outlined. The House of Delegates authorized establishment of an AMA reinsurance company to provide support for those state societies where it has been necessary to start a physicians liability company. In addition, the state by state legislative remedies which are being considered or are already law are to be made available to any state on request along with the staff resources of the AMA. Finally, the House approved a statement on the "Physician's Commitment to Patients and the Physician's Practice Rights" which details AMA position in relationship to the "strikes" and "slow downs" across the country in response to the malpractice problem.

These specific problem areas were faced along with a whole "book full" of

others and in each case I felt the AMA as represented by the elected delegates acted responsibly. Our national medical organization **must** be able to speak for all physicians in the country, and it can do so only when each of us supports the AMA. During this time of repeated crises in our relations with various levels of government and other "third parties," if the AMA didn't exist, we would be frantically working to organize it!

The "new look" of the AMA is here—join us in its active support.

Harrison L. Rogers, M.D.
AMA Delegate
Suite 601
1938 Peachtree Road, N.W.
Atlanta, Georgia 30309





MAG President David A. Wells (above, left) presents proposals to Senate Human Resources Committee members Julian Bond and Ed Garrard of Atlanta, Bert Hamilton of Macon and W. W. Fincher of Dalton. News media representatives (above, right) line the wall behind Senate committee members (L-R) Steve Reynolds, Lawrenceville, Perry Hudson, Hapeville and Sidney Marcus of Atlanta.

MAG SUGGESTS MALPRACTICE INSURANCE CHANGES TO SENATE COMMITTEE

Seeking to head off a future malpractice crisis in Georgia, MAG President David A. Wells of Dalton presented some ameliorative suggestions to the Senate Human Resources Committee in mid-July hearings. The committee is considering two of four bills introduced on the subject in the last session of the General Assembly.

Reducing the statute of limitations, setting up an arbitration committee, preventing the reporting of large settlements in the newspapers and bringing all sources of payment to the claimant to the attention of the jury were the four suggestions made by Dr. Wells.

He noted that the situation in Georgia has not reached the crisis stage, in fact the state ranks 43rd lowest in the nation in the cost of such insurance, but that action must be taken now to prevent problems in the near future.

Current Georgia law allows claims to be made two years after discovery of a condition. This clause makes it difficult for insurance companies to predict the number of cases and amount of claims that might be paid in future years. MAG proposes that a statute of limitation be placed so that claims must be made within two years of date of incident or one year from the date of discovery for those conditions discovered late within the initial two year period. Children under six would have until the eighth birthday to file a claim. A clause would be included to allow one year after the discovery of a foreign object for a claim to be filed during the life of a claimant.

A second proposal would establish a voluntary binding arbitration panel composed of a non-voting attorney as chairman, one M.D. appointed by the plaintiff and one by the defendant and one agreed upon by both parties. Plaintiffs choosing to go to court would, if they lose, pay court costs and compensate the physician for his time. Findings by the committee or court against the physician would be turned over to the Board of Medical Examiners.

Thirdly, MAG suggests the removal of the *ad damnum* clause pertaining to pleadings. Lawyers could not plead the amount sought by the suit, nor would this be reported publicly. The insurance industry feels many suits are filed strictly because an individual reads of other suits in which large amounts were awarded to the plaintiff.

Finally, more appropriate judgments for a claimant might be rendered by juries, MAG feels, if all sources of income for the claimant were made known. Frequently he is covered by insurance and/or workmen's compensation, etc., and smaller settlements in a malpractice judgement would care for his needs.

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Current Programs in Professional Education of the American Cancer Society

RAYMOND H. BUNSHAW, M.D., *Atlanta**

Regional Medical Student Conferences

LAST JANUARY THE National Society of the American Cancer Society sponsored a pilot regional medical student conference at Emory University of a day and a half duration. Approximately 165 junior and senior medical students selected by their deans from the University of Mississippi, University of Alabama, Medical College of Georgia and Emory University attended. All expenses, including transportation and living involved in the conference, were paid by the National Society.

The program was prepared by the faculties of the four schools and featured multiple small group discussions. Each student was permitted to select the conference he wished to attend. The discussions covered surgery, chemotherapy, radiation and immunotherapy, early detection, cancer markers, viruses, risk factors, mammography, relationships of the physician, patient and family and other subjects. In addition, a sizeable part of the program was devoted to multidisciplinary presentations involving a patient with Hodgkin's Disease. An effort was made to give the student a brief orientation on the activities of the American Cancer Society and the National Cancer Institute.

Most students felt that the conference was a good overview of cancer and was stimulating and highly informative. They were anxious to obtain the latest information available from basic research and clinical investigation of cancer. They valued the opportunity to discuss experiences with students from other schools. One student wrote: "I learned more here than in the last four years at medical school about oncology."

Similar conferences are now in the planning stage in Tennessee, Kentucky, Indiana and other states. The American Cancer Society considers it highly desirable to cultivate an active interest in cancer in the medical student and to indoctrinate him with the hopeful aspects and curability of the disease during the formative stages of his medical career.

Training Centers for Colonoscopy

Colonoscopy is rapidly gaining a place in the diagnosis and treatment of cancer of the colon and rectum. In recognition of this fact, the American Cancer Society and the National Cancer Institute jointly plan to open six training centers for physicians. A pilot training project based in New York City, with Dr. Paul Sherlock, chief of gastroenterology of Memorial Hospital, serving as project director, will open. Memorial, Beth Israel, Mt. Sinai, New York and Columbia Presbyterian Hospitals will participate in the project and the course will be one week in length.

* Vice President, Southern Area Medical Affairs for the American Cancer Society, Inc.

Although the first course will probably be held in early fall, no information is available about numbers to be trained and tuition and applications are not being received. As soon as further information is available, it will be disseminated widely.

Professors of Clinical Oncology

Currently there are 12 professors of clinical oncology approved by the National Society for a five-year period established in various medical schools around the country. The salary of the individuals occupying the position is partially paid by the appropriate state division of the American Cancer Society. The program is popular and it is expected that oncology professorships will be established in other medical schools of the nation. The latest one approved was at the Medical College of Wisconsin.

Films for Professional Audiences

The American Cancer Society has produced approximately 40 professional films that are available to professional audiences. They came in various widths suitable for projection by different types of equipment and are also available as video tapes. The latest film to be approved for distribution is on "Hodgkin's Disease and Other Malignant Lymphomas." Films appropriate for medical, dental and nursing audiences are stocked at the Division Office in Atlanta.

Nursing Program, National Conferences

A pilot educational program in oncological nursing for instructors in nursing to be carried out in a university setting is planned. Announcements will be made about details of this program in the future when plans are finalized.

Two National professional conferences will be held in the next year. A conference in gynecologic cancer will be held at the Marriott Hotel, Philadelphia, Pennsylvania, September 18-20, 1975. A radiation oncology conference is scheduled at the San Francisco Hilton Hotel May 27-29, 1976. Credits for attendance at these conferences are awarded by the AMA, American Academy of Family Physicians and specialty societies.

Program information: Additional information about these programs and other cancer programs and projects may be obtained by communicating with the Georgia Division, American Cancer Society, 2025 Peachtree Road, N.E., Suite 14, Atlanta, Ga. 30309. Telephone (404) 351-3650. ■

INTERDISCIPLINARY PROGRAM EXPLORES CANCER PROBLEMS

An Emory Interdisciplinary Symposium on Cancer-Related Problems will be presented October 31 and November 1, 1975 (Friday and Saturday) on the Emory campus.

The problem areas considered in the three major sessions are those related to lesions of the head and neck, tumors of the colon and rectum and chemotherapy and immunotherapy considered jointly in one session. Instead of formal lectures, the format will include full exploration of problems in the several areas presented both by the faculty and participants, who will be able to ask questions.

The faculty will be made up of representatives of all participating disciplines including a radiologist, pathologist and radiotherapist of Emory School of Medicine. One or more guest resource experts will participate in each problem area.

The program will be held in the Harry Williams Auditorium, Room 128 of the Anatomy-Physiology Building of Emory. Registration fee is $75, and includes continental breakfast each morning, lunch the first day and a full buffet in the evening at the Druid Hills Golf Club, where a cash bar will be available. Approximately 10 hours of credit for continuing medical education will be given as well as a certificate for attendance.

As an added feature, football tickets to the Duke-Georgia Tech Homecoming game have been reserved, and those interested should respond immediately, sending a check for $7.50 per person made payable to Dr. Sam A. Wilkins, Jr., Chairman, Emory University Clinic, Atlanta, Ga. 30322.

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A Look at Lipoproteins

JACK E. DAWSON, JR., M.D., *Atlanta**

In preventive cardiology detection and treatment of hyperlipidemias is important because it ranks with smoking and hypertension as one of the three major risk factors. The identification of hyperlipidemias by the determination of cholesterol and triglyceride levels has been a confusing issue because these tests alone have not reflected all of the lipoproteins. Criteria for phenotyping has become very sophisticated and complex. The five major phenotypes have been characterized by use of clinical data including patient diagnoses and physical findings as well as serum studies which include the various lipoprotein levels, electrophoretic and ultracentrifugation data.[1]

Fredrickson[2] and Havel[3] in February editorials focus our attention on the practical approach to phenotyping lipoproteins by use of cholesterol and triglyceride levels alone. Additional information is obtained by observing accompanying serum specimens after the blood clot has settled. Types I, III and V hyperlipidemias can readily be identified by cloudy or creamy sera. The clear specimens usually include Types II and IV. Type IIa is predominantly elevated cholesterol and Type IV is predominantly elevated triglyceride. The phenotyping of hyperlipidemias in an office practice can therefore be made by inference by correlating the known data of the five major phenotypes with the serum cholesterol and triglyceride plus the character of the serum. This method should be more practical and economical for the patient as well as reserve the details of the more complex lipid evaluations for the lipid specialist and researcher.

Phenotypes Associated With Heart Disease

Types II and IV are more commonly associated with coronary atherosclerotic heart disease and there are overlapping primary and secondary etiologies which alone accelerate atherogenesis. Possibly the overlapping of the various risk factors in the individual patients accounts for phenotype and genotype discrepancies when family members of patients with coronary atherosclerotic heart disease are screened. The Seattle Study[4] found Types IIa, IIb and IV distributed in equal numbers in such families. Once the specific phenotype is detected and determined to be a risk factor it is then useful in selecting a therapeutic approach and in predicting a patient's prognosis.

Controlling the lipids by the simplest dietary and/or drug approach along with the correction of other pertinent risk factors is the aim of therapy. The "fat-control" diet is under discussion in both pediatric and adult cardiology groups. More restrictive diets are difficult for the patient to adhere to on a long term basis and patient laxity seems common. Re-evaluation of the lipids at two month intervals provides an opportunity for dietary and drug manipulations to insure the maximum

* Cardiologist whose practice is at 478 Peachtree St., N.E., Atlanta, Ga. 30308. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

effectiveness of the program. These diets alone usually control the serum lipids of patients with Types III, IV and V hyperlipoproteins while adjunctive drugs are usually necessary in the optimal control of Type II patients. ■

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1. Fredrickson, D. S., Lees, R. S.: A system for phenotyping hyperlipoproteinemia; *Circ.* 31:321, 1965.
2. Fredrickson, D. S.: It's time to be practical; *Circ.* 51:209-11, Feb. 1975.
3. Havel, R. J.: Hyperlipoproteinemia: Problems in diagnosis and challenges posed by the "Type III" disorder; *Ann. Intern. Med.* 82:273-4, Feb. 1975.
4. Goldstein, J. L., Schrott, H. R., Hazzard, W. R., Bierman, E. L., Motulsky, A. G.: Hyperlipidemia in coronary heart disease. II. Genetic analysis of lipid levels in 176 families and delineation of a new inherited disorder, combined hyperlipidemia. *J. Clin. Invest.* 52:1544, 1973.

OUTSTANDING SPEAKERS SCHEDULED FOR HEART ASSOCIATION SCIENTIFIC SESSIONS

Many outstanding physicians from Georgia and other parts of the nation will be program participants at the Georgia Heart Association's annual Scientific Sessions for Physicians, scheduled September 12-14 in Atlanta.

The out-of-state speakers are Agustin Castellanos, Jr., M.D., University of Miami School of Medicine, Miami, Fla.; Glenn M. Friedman, M.D., Papago Buttes Pediatric Center, Scottsdale, Ariz.; Julien I. E. Hoffman, M.D., F.R.C.P., University of California School of Medicine, San Francisco, Calif.; and Charles Rob, M.D., University of Rochester Medical Center, Rochester, N. Y.

Dr. Rob will speak at the opening session Friday afternoon, September 12 when the topic will be "Cerebral Vascular Disease." Other featured speakers the first day are Herbert R. Karp, M.D., Emory University School of Medicine, Atlanta, and Taher El Gammal, M.D., Medical College of Georgia, Augusta.

Dr. Castellanos will headline Saturday morning's session on "Permanent Cardiac Pacemaker." A special feature will be six simultaneous seminars on "Cardiology Problem Solving."

On Sunday morning, Dr. Hoffman and Dr. Friedman will speak on "Natural History of Congenital and Acquired (Atherosclerosis) Heart Disease."

The Saturday seminars on "Cardiology Problem Solving" will each feature the presentation of three patients who represent common problems in adult and pediatric cardiology. The audience will be encouraged to select and interpret clinical data in order to synthesize cardiovascular problems and in turn recommend approaches to management.

Topics for the seminars are "Three Patients with Unstable Angina Pectoris," "Three Patients Presenting with Syncope," "Three Infants with Cardiac Distress," "Three Patients with Interesting Heart Murmurs," "Three Patients Presenting with Cardiac Arrhythmias" and "Complicated Acute Myocardial Infarctions."

The Georgia Heart Association's weekend of meetings will get under way Friday morning with an Annual Meeting General Session for all Heart Association members and other volunteers. All meetings will be held at the Royal Coach Motor Hotel.

The annual luncheon, during which new officers and members of the board of directors will be elected, will begin at noon. Robert G. Ellison, M.D., of Augusta, is current president of GHA, and C. Daniel Cabaniss, M.D., of Columbus is president-elect.

Also included in the series of meetings will be Scientific Sessions for Nurses, Friday through Saturday, and a new Scientific Session for Dietitians and Nutritionists on Saturday.

To register, write the Georgia Heart Association, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324; or phone (404) 261-2260.

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Hospital Utilization Review Under Medicare

J. WINSTON HUFF, *Atlanta**

BOTH THE LAW and regulations require utilization review of Medicare hospital cases. Hospital administrators and hospital medical staffs sometimes are not sure just who should perform this function. Some misinformation has come from various sources, including the Social Security Administration itself. It is the purpose of this article to attempt to explain where this utilization review burden must fall.

Section 1861(k)(2) of the Social Security Act provides that U/R should be conducted:

> "By *either* (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, *or* (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality or (ii) if (and for so long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary. . . ." [emphasis added]

Also, Medicare regulations which become effective July 1, 1975, state:

> "The utilization review function is performed by a staff committee of the hospital composed of two or more physicians with participation of other professional personnel, *or* by a group outside the hospital which is similarly composed and which is established by the local medical or osteopathic society and some or all of the hospitals and skilled nursing facilities in the locality *or* by a group established and organized in a manner approved by the Secretary that is capable of performing such function." [emphasis added]
> 20 CFR #405.1035(e)(1)

One would think this is pretty plain. The regulation states that utilization review may be conducted by:

Option #1—an in-hospital committee of staff physicians;

or

Option #2—an outside group of physicians if the outside group is set up by the local medical society with participation of some area hospitals and skilled nursing homes;

or

Option #3—an outside hospital group of physicians not described in Option

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* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

#2, but *only* if there is no local medical society sponsoring this work. In this Option #3, the outside group has to be approved by the Secretary of HEW.

Neither the statute nor the regulations express any preference between Option 1 and Options 2 and 3. It is equally clear that an outside group of physicians not connected with a local medical society can be employed *only* if there is no local medical society group doing this work. The statute does state that the review committee must be established under options #2 or #3 if the institute is so small a properly functioning committee cannot be provided.

Some of the information physicians have received from HEW would lead one to believe that Option #1 (an in-house committee) must be used if the participating hospital has the capacity to do the work; and that Options #2 and #3 are available only if the hospital staff itself is incapable of doing the review—such as in very small hospitals. If these releases (and those from Georgia's Department of Human Resources as well) are carefully read, they indicate that HEW and DHR prefer an in-hospital committee. For example, a recent State Operation Manual says:

> "Typically and preferably, where a hospital has a sufficiently large staff the utilization review committee is, as in the words of the law, comprised of a 'staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel.' "

The in-hospital committee may be "typical" and "preferable," but, as stated, it does not appear to be required by the law or regulations if the other options are chosen.

Some other news releases by interested groups would indicate that Option #3 is as equally available as Options #1 and #2. As stated above, this is not the case. Options #1 and #2 are equally available; however, Option #3 is available only if there is no review group by the local medical society, and the outside committee is approved by the Secretary of HEW.

In specific cases, advice should be sought from the particular institution's attorney. ■

HIGHLIGHTS OF EXECUTIVE COMMITTEE
July 13, 1975

Continuing Medical Education Program for Physicians' Assistants: Approved a request for travel expenses for one speaker for a program October 3-4, 1975 sponsored by the Emory University Physicians' Assistant Program.

AMA vs HEW on Utilization Review: Heard a report from the MAG legal counsel that a three-judge panel has heard AMA and HEW's appeals and a decision should be announced soon. A similar suit filed by the Medical Society of the State of New York on the same day has been deferred pending a decision on the AMA suit.

Progress Report on HSA's: Heard a report that there is organizational activity in each of the six HSA areas.

Professional Liability Insurance: Heard a report from the Committee in which were outlined four suggested legislative changes that would help to decrease the malpractice problems in Georgia, thereby, hopefully, maintaining or reducing professional liability insurance premiums: 1) arbitration, with the losing party paying all expenses; 2) elimination of the ad damnum clause; 3) identifying collateral sources of payment to claimants; 4) establishing a statute of limitations that would prevent claims being brought against the doctor beyond two years after the incident. These recommendations will be brought before a Senate Human Resources Committee hearing in the near future.

CHEC Program: It was reported that operating workshops for CHEC personnel will begin July 15.

Appointments: Subcommittee on Continuing Medical Education, T. Eugene Kennedy, Buford. Ad Hoc Committee on Bicentennial Celebration: Peter Scardino, Frank Carlton and John Kirk Train of Savannah; Herbert S. Alden, Crawford F. Barnett, Phinizy Calhoun, Robert L. Brown, and Walter C. McGraw, Atlanta; Walter Shepeard, Augusta; Donald R. Rooney, Marietta; Dr. Robert Cunningham, ex-officio, History Department University of Georgia in Athens; Dr. Stuart Galishoff, ex-officio, History Department, Georgia State University, Atlanta.

I've told this before . . . .

(Ed. note: Sometimes little things are overlooked in the rush of taking care of a clinic full of patients, as shown in this story by a new contributor, N. Thornton, M.D. of Augusta. Articles for this page should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Foul-Up on the Assembly Line

THE GYN CLINIC at the big metropolitan hospital provided us with much work and always some interesting pathology. At times the numbers of patients were overwhelming and we became very dependent on the nurses (also students as we were) to finish up so we could go on to the next examining room.

Following one long, arduous afternoon in the clinic, the four of us staggered off to the snack bar to replenish our blood coffee level before making evening rounds with the attending gynecologist. The paging system suddenly called one of our group to the phone. He returned in a few minutes hardly containing his laughter.

"That was the husband of one of my patients from this afternoon. He said we'd left an instrument in his wife and wanted to know how long it would have to stay!"

We all roared, visualizing the speculum she somehow had managed to keep in. Then we wanted to know what he told the man.

"I said, 'What time do you have now?,' and he said, '6:30.' So I told him to leave it in until 7:30, take it out, rinse it off and return it to us tomorrow!"

N. Thornton, M.D.
Veterans Administration Hospital
Augusta, Georgia 30904

VICTORY FOR OPHTHALMOLOGISTS IN COLORADO COURT

(Ed. note: The following review of an important court judgement against optometrists is reprinted from the March 1975 issue of "The Ophthalmologist," with permission from its parent organization, The American Association of Ophthalmology. This is a timely follow up to the editorial in the April JMAG, *"Ophthalmology, Optometry and the Law." Written by Richard K. Winston, president of the Georgia Society of Ophthalmology, it discusses the tug of war between ophthalmologists and optometrists for favorable legislation in the 1975 and earlier sessions of the Georgia General Assembly. Organized optometry in Georgia has consistently sought to pass legislation which would, in effect, make it possible for optometrists to further their aims in becoming the primary delivery system for eye care in the United States. The following article was titled, "Colorado Court Permanently Enjoins Optometrists from Detecting or Diagnosing Glaucoma and Prescribing Any Soft Contact Lenses for Corrective or Therapeutic Measures.")*

After a trial on the merits Judge Robert T. Kingsley, on February 5, 1975 entered *Findings of Fact and Order* in favor the plaintiff ophthalmologists, in Civil Action No. C-33782 entitled *Lawrence A. Winograd, et al v. C. E. Johnson, et al* and against the optometrist defendants, in the District Court in and for the City and County of Denver, Colorado.

Judge Kingsley found that: (1) glaucoma is a disease and can be diagnosed only by medical doctors and not by optometrists; (2) detecting and diagnosing glaucoma are the same; and (3) a soft contact lens may not be prescribed by optometrists for corrective or therapeutic measures.

Accordingly, Judge Kingsley by Order directed that the defendant optometrists and those in like position: (1) cease announcing or holding themselves out as being able to diagnose or detect the presence or absence of glucoma; (2) cease prescribing any type of soft contact lenses for corrective or therapeutic measures; and (3) cease the use of any tonometer which requires the use of an anesthetic.

The plaintiff ophthalmologists and their counsel are pleased with the permanent injunction entered against optometrists and state that it serves the public interest. It is a significant victory and represents a major contracture of the aims of optometrists to relegate ophthalmology to a secondary and subservient position in the field of eye health care to optometrists who asserted during the trial that optometry should be the primary delivery system for eye care in the United States.

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NEW MEMBERS

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SOCIETIES

The August meeting of the **DeKalb County Medical Society** was a family picnic at the home of Dr. and Mrs. Ralph Tillman in Lawrenceville. The July meeting included a panel discussion on "The Malpractice Crisis" with L. C. Buchanan, as moderator, Johnnie L. Caldwell, comptroller general for Georgia; William W. Moore, Jr., chairman of MAG Insurance Committee, and Steve Manthe, marketing manager for the St. Paul Company.

Georgia Medical Society sponsored its Third Annual Symposium on Athletic Injuries August 9 at the medical society headquarters. Among the physician speakers were Keith A. Dimond, Paul F. Jurgensen, Leslie L. Wilkes, Glenn L. Whitecotten and C. Walker Beeson.

Georgia Tech coach Pepper Rodgers was to be the featured speaker at the Annual Parent-Child Dinner Meeting of the **Medical Association of Atlanta** August 12. S. Robert Lathan, Atlanta internist, has been named new editor of *Atlanta Medicine,* effective with the August issue. Dr. Lathan has served as an associate editor for several years. He replaces Nicholas E. Davies, who had served as editor since 1971.

PERSONALS

Seventh District

MAG president **David A. Wells** of Dalton addressed aspiring applicants for the State Medical Education Board scholarships in a July meeting. He told the 58 applicants for 40 scholarships that his own family practice field was "the best of all the specialties."

THE ASSOCIATION / Continued

Cartersville pediatrician **Judy Orosz** spoke to the June meeting of the Cartersville Rotary Club, explaining new equipment and programs for children begun at the Sam Howell Memorial Hospital.

Ninth District

Duke University graduate **Edwin L. Jones** has joined the pediatrics practice of Martin H. Smith, Lowell Peacock and Charles L. Jones in Gainesville. Dr. Jones served a pediatric internship and progressed to chief resident in pediatrics at Baylor University College of Medicine in Houston, Texas and has spent the past two years as chief of pediatrics at the Indian Health Hospital in Claremore, Oklahoma.

Bipin Thakrar has begun the practice in general surgery in Clarkesville. The native of India trained in Bombay, India, practiced in India, then the United States and England before working in Central Africa for six years. While in England he became a Fellow of the Royal College of Surgeons. His wife, Devi, is working to obtain her Georgia license and to begin a practice in gynecology-obstetrics and anesthesiology.

Tenth District

Wilbur E. Baugh, Milledgeville radiologist, has been given a lifetime honorary membership in the Georgia Pharmaceutical Association, the second man in 10 years to receive the honor. Dr. Baugh is a state representative from the 108th District and serves on the Health and Ecology Committee.

Two 10th district physicians have authored articles in the July *Southern Medical Journal:* **Fayette M. McElhannon, Jr.,** of Athens, "Congenital Pseudarthrosis of the Tibia" and **Carl Jelenke,** of Augusta, "Fluid Shifts After Burn Injury."

DEATHS

Olin S. Cofer

Atlanta physician Olin S. Cofer, 83, died June 31. He was active in the Medical Association of Atlanta, 5th District Medical Society, of which he was past president, Southern Medical Association, American College of Surgeons and was past president of the Southern Gynecological and Obstetrical Society.

Dr. Cofer, a Gwinnett County native, was graduated from Emory University. His internship was served at Piedmont Hospital in Atlanta, and the Women's Hospital in New York. Postgraduate work was completed in New York, Cook County Hospital in Chicago and the Mayo Clinic.

During World War I he served as a first lieutenant in the U.S. Army Medical Corps, later beginning practice in Smyrna.

Dr. Cofer was a past president of the Georgia Baptist Hospital Staff and was on the staffs of Grady Memoral and Crawford W. Long hospitals.

Survivors include his widow, the former Myrtle Bonner; son, Hyatt B. Cofer of Chattanooga, Tenn.; sisters, Mrs. A. M. Bennett of Conyers, Mrs. Sitara Dolphin of Seattle, Wash. and brother, Frank Cofer of Ft. Pierce, Fla.

VOLUNTEERS SOLICITED FOR STUDY ON EXERCISE FOR HEART ATTACK PATIENTS

Emory University School of Medicine is one of four centers participating in a national study of men suffering recent heart attacks to determine the value of regular exercise and physical fitness programs in preventing further attacks.

The study is part of the National Exercise and Heart Disease Project and funded by the Rehabilitation Services Administration of the Department of Health, Education, and Welfare. Other collaborating centers are Case Western Reserve University in Cleveland, Ohio, The George Washington University in Washington, D. C. and the University of Alabama in Birmingham.

A media campaign has been launched to secure volunteers, and patients may be contacting their physicians for the consent needed. The study is looking for men 30 to 64 years of age who have had a heart attack within the last 36 months. Each will be given a free treadmill test and cardiac evaluation, and asked to complete a six-week program of supervised exercises receiving constant ECG monitoring and exercises tailored to his individual working capacity. These sessions will be held three times a week at either Georgia Baptist Hospital or the Decatur-DeKalb YMCA and will run one hour each during convenient early morning, late afternoon or early evening hours.

Results of periodic evaluations will be forwarded to each participant's physician, and apart from this program, each patient will be cared for by his personal physician.

Following the initial screening period, the volunteers will be divided on a random basis into either an Exercise Training Group (ETG) or Non-Training Group (NTG). Those in the ETG will participate in an intensive, prescribed and supervised eight-week training program directed toward obtaining a significant aerobic training effect. After this time, they will continue to exercise in long-term physical activity programs supervised by Emory. Those in the NTG will be encouraged to maintain their "normal routines" but will not participate in an exercise program.

Some of the objectives of the program are to determine: 1) the effects of the program on cardiovascular responses; 2) the effects of the exercise program on social and vocational adaptation for productive living; 3) the effects of the program on psychological adaptation as reflected by changes in anxiety and depression; 4) the operational problems of a long-term physical activity program; and 5) the effects of the program on mortality rate, recurrent myocardial infarction and occurrence of complications.

Accredited Continuing Education Programs in Georgia

THE LIST OF INSTITUTIONS and organizations in Georgia accredited for their continuing medical education programs continues to grow. Accreditation means that the American Medical Association recognizes both the quality of a program and the educational experience of its directors. Some institutions, such as the medical schools, are accredited directly by the AMA, while others are accredited through the AMA's approved state affiliate, the Medical Association of Georgia.

The following is a list of accredited institutions and organizations in Georgia along with the programs which they sponsor:

1. The Medical College of Georgia, Augusta. Contact Glen Garrison, M.D., for information on specific programs.

2. National Center for Disease Control (CDC), Atlanta. Contact W. N. Davey, M.D., for information on specific programs.

3. Emory University School of Medicine, Atlanta.

   a. Medical Conference, Wednesdays, 12-1 p.m.
   b. Cardiology Conference, Wednesdays, 12-1 p.m.
   c. Medical Grand Rounds, Thursdays, 12-1 p.m.
   d. Pediatric Grand Rounds, Thursdays, 9-10 a.m.
   e. Head and Neck Disease Seminar, last Wednesday of each month, 1:30-2:30 p.m.
   f. Postgraduate Laparoscope Course, September 18-20, October 16-18, December 11-13. (Contact: W. Newton Long, M.D., Department of Ob-Gyn.)
   g. Neurosurgery Continuing Education Workshop on Pituitary Gland, September 20-21. (Contact: George T. Tindall, M.D., Department of Neurosurgery.)

4. Georgia Academy of Family Physicians. Annual Scientific Meeting, November 18-22, Atlanta.

5. Georgia Heart Association. Annual Scientific Session, September 12-14, Atlanta.

6. Piedmont Hospital, Atlanta

   a. Cardiac Review Conference, Mondays, 8-8:30 a.m.
   b. Endocrinology Session, Tuesdays, 8-9 a.m.
   c. Medical Conference, Wednesdays, 8-9 a.m.
   d. Pulmonary Conference, Thursdays, 8-9 a.m.
   e. Cardiology Conference, Fridays, 8-9 a.m.

7. Atlanta Graduate Medical Assembly. Annual Scientific Meeting, March 14-17, 1976.

8. Atlanta Society of Pathologists. Slide Seminar, Second Wednesday of each month (beginning in September), 8-10 p.m. (Contact: David Stacy, M.D.)

9. The Medical Center, Columbus.

   a. Day with Emory Conference, third Tuesday (October-May), 8:30-9:30 a.m.
   b. Gross Anatomic Conference, first Friday, 9-10 a.m.
   c. Clinical Neuropathology Session, third Friday, 9-10 a.m.
   d. Medical Grand Rounds, Tuesdays, 8:30-9:30 a.m.
   e. Ob-Gyn Grand Rounds, Tuesdays, 5:30-6:30 p.m.
   f. Genetic Counselling, third Tuesday, 1-4:30 p.m.
   g. Family Practice Grand Rounds, every other Wednesday, 12:30-1:30 p.m.
   h. Surgical Grand Rounds, Fridays, 12:30-1:30 p.m.
   i. Pediatric Grand Rounds, Thursdays, 8:30-9:30 a.m.
   j. Orthopedic Fracture Conference, Mondays, 6-7 p.m.
   k. Surgical Pathology Conference, Wednesdays, 11:30-12:30 p.m.
   l. Joint Obstetric-Pediatric House Staff Conference, Thursdays, 12-1 p.m.

10. The Medical Center of Central Georgia, Macon. Contact: Robert Donner, M.D., for information on specific programs.

11. Southeastern Angiographic Society. Fall Scientific Meeting, October 23-26, New Orleans. Contact: William A. Miller, M.D., Savannah.

12. Northside Hospital, Atlanta

   a. Subjects on Internal Medicine (Clinical Conference), Thursdays (with exception of second Thursday), 8-9 a.m.
   b. Tumor Conference, First Tuesday, 12:30-1:30 p.m.
   c. Selected Subjects in Emergency Medicine
   d. Ob-Gyn Clinical Conference, third Monday, 6-7 p.m.
   e. Pediatric Clinical Conference, fourth Tuesday, 8-9 a.m.

f. Psychiatry Clinical Conference, fourth Tuesday, 7:15-8:15 p.m.

g. General Practice Clinical Conference, fourth Tuesday, 7:30-8:30 p.m.

h. Surgical Clinical Conference, first Tuesday, 7-8 p.m.

13. American Cancer Society, Georgia Division. Contact: Shirley Preston, American Cancer Society in Atlanta, for information on specific programs.

14. Georgia Radiological Society. Fall Scientific Meeting, November 21-22, Atlanta. Contact: William A. Miller, M.D., Savannah.

OPPORTUNITIES FOR CONTINUING MEDICAL EDUCATION

NATIONAL CANCER CONFERENCE ON CANCER RESEARCH AND CLINICAL INVESTIGATION
September 20-22, 1975
Regency Hyatt House, Atlanta
Contact: Evadne Gerrard, American Cancer Society, 219 E. 42nd St., New York, N.Y. 10017

SECOND ANNUAL CARDIOVASCULAR SYMPOSIUM
September 25-27, 1975
Gainesville Hilton Inn, Gainesville, Fla.
Contact: Howard W. Ramsey, M.D., North Florida Regional Hospital, P.O. Box 13494, Gainesville, Fla. 32604

SCIENTIFIC FOUNDATIONS FOR CLINICAL PRACTICE
September 26-28, 1975
Fee: $45
Contact: Frank R. Lemon, M.D., Office of Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506

AMERICAN THERMOGRAPHIC SOCIETY ANNUAL MEETING
September 27-28, 1975
Marriott Motor Hotel, Atlanta
Contact: Georgia Revesz, Temple University School of Medicine, Radiology Research Laboratory, 3401 N. Broad St., Philadelphia, Pa. 19104

SOCIETY FOR PEDIATRIC RADIOLOGY
September 28-29, 1975
Marriott Motor Hotel, Atlanta
Contact: J. P. Dorst, M.D., Johns Hopkins Hospital, 601 N. Broadway, Baltimore, Md. 21205

AMERICAN ROENTGEN RAY SOCIETY
September 30-October 3, 1975
Marriott Motor Hotel, Atlanta
Contact: James F. Martin, M.D., 300 S. Hawthorne Road, Winston-Salem, N.C. 27103

SOUTHERN PERINATAL ASSOCIATION
October 1-4, 1975
Birmingham, Ala.
Contact: L. Blackman, M.D., Duke University Medical Center, P.O. Box 3936, Durham, N.C. 27710

ANNUAL SCIENTIFIC MEETING, GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
October 2, 1975
Stouffer's, Atlanta

SOUTHEASTERN CANCER RESEARCH ASSOCIATION
October 2-4, 1975
Sheraton-Biltmore, Atlanta
Contact: W. E. Criss, M.D., Dept. of Ob-Gyn, University of Florida College of Medicine, Gainesville, Fla. 32610

FAMILY PRACTICE SYMPOSIUM
October 13-17, 1975
Contact: Division of Continuing Education, MCG, Augusta, Ga. 30902

GEORGIA ORTHOPEDIC SOCIETY ANNUAL MEETING
October 16-19, 1975
Sea Island, Ga.

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The Month in Washington

The unusual one-day "public oversight" hearings of the House Ways and Means Committee's Health Subcommittee to determine if the Department of Health, Education and Welfare is superseding Congressional intent in an increasing number of Medicare cost-control regulations was marked throughout by angry confrontation between the HEW Secretary and health providers.

Undaunted by a solid array of heated opposition from medical and hospital groups, Secretary Caspar Weinberger told the Subcommittee that the four disputed Medicare regulations will save about $250 million a year and "improve the quality of care."

The hearing bringing together Weinberger and his critics was called by Subcommittee Chairman Dan Rostenkowski (D.—Ill.) who said he was sorry the confrontation had to take place. "I hope the Subcommittee can remove roadblocks. We should really try to get the government and the health care industry out of the courtroom and into the conference room where the debate belongs."

Four lawsuits have been filed against the HEW Department to overturn the regulations. Members of hospital and physicians' groups including the American Medical Association, urged the lawmakers at the hearing to crack down on HEW for going beyond the intent of law. But there was little indication from the Subcommittee that any swift action is contemplated.

Weinberger, easily fielding most of the Subcommittee's questions, refused to acknowledge any merit in the private sector's slashing attacks on the regulations, insisting the regulations followed the intent of Congress and were needed to curb costs. He suggested the remedy would be in seeking to have Congress change the laws, rather than in suing HEW.

Disputed Regulations

The regulations under fire:

- Social Security's Utilization Review (UR) final regulations requiring elaborate institutional post admission review mechanisms.
- Reducing the schedule of limits on hospital inpatient general routine service costs from the 90th to the 80th percentile.
- Limitation on recognition of physicians' prevailing charge increases, based on an economic index.
- Termination of the inpatient routine nursing salary cost differential.

Stressing a common theme among the witnesses, the AMA cited "a general feeling of futility concerning administrative action felt by the public as a whole, but especially by groups subject to and particularly affected by federal regulation." Ernest T. Livingstone, M.D., Chairman of the AMA Council on Legislation, said many professional associates display "an attitude often of exasperation, consternation and indignation with respect to the bureaucratic administration of government programs.

"Administrative regulations," Dr. Livingstone said, "often expand upon or subvert the intent of Congress." This is why, he explained, the AMA for the first time in its history recently sued the HEW Department, over the UR regulations. Federal Judge Julius Hoffman upheld the AMA's contentions and issued a restraining order against carrying out the UR rules. The HEW Department has recommended that the case be appealed.

A key AMA argument was that admission review within 24 hours is directed almost solely to protect hospitals against possible non-reimbursement—not the patient's health. Judge Hoffman said that if "patients who cannot pay cannot be hospitalized when diagnosis is unclear, the potential injury to the patient's health may be irreparable."

Edgar T. Beddingfield, M.D., Vice Chairman of the AMA Council on Legislation, said HEW barged ahead on the physicians' Medicare fee index without giving interested parties a chance to question the details of the regulations. There is no justification in either the law or its legislative history for imposition of a national economic index, Dr. Beddingfield told the panel, noting that Medicare fee recognition "has long lagged behind current trends in physicians' fees. Because of the unique two-year delay, he said the index limitations could result in shifting the financial burden to Medicare-Medicaid patients by driving reimbursement further below realistic fees.

Also criticizing the Medicare fee constraints, John Alexander McMahon, President of the American Hospital Association, said "this unilateral arbitrariness is precisely the problem with the general approach to program economic controls adopted by the Social Security Administration in carrying out its responsibilities. It clearly suggests that SSA continues to utilize law to suit its own concerns and not to reflect in a careful and publicly acknowledged way a commitment to honor legitimate costs in the delivery of health care."

Medicare Payment Formula

The physicians' Medicare fee index angrily debated by the AMA and the HEW Secretary during the Ways and Means Health Subcommittee "public oversight" hearing, limits reimbursement to 17.9 percent above levels prevailing in fiscal year 1973.

Now in effect, the new payment formula, according to HEW Secretary Weinberger, will save the government an estimated $26 million during this fiscal year out of a total Medicare Part B outlay of $3.2 billion.

Most of the objections to the national formula which is pegged to various cost-of-living indexes were brushed aside by HEW and Social Security in issuing the regulations in final form.

The AMA has charged that Congress intended local, rather than national indexes; that the limitation was not supposed to be on a procedure-by-procedure basis but an aggregate; and that HEW allowed insufficient time for discussion on the manner in which it has decided to draw up the index. The control will simply force more physicians to abandon the assignment method, AMA warned.

Weinberger argued that while the Senate Finance

MONTH IN WASHINGTON / Continued

Committee report suggested that a separate index for each locality be calculated, "a national index is being used, at least initially, because the data required to construct local indices are not now available."

The index will be applied to every prevailing charge in each locality. It will also be applied on a cumulative basis with fiscal 1973 serving as the base year. Increases in prevailing charges over the 1973 base year level cannot exceed the rate justified by the economic index calculated for that period.

Any individual prevailing charge that would increase by more than 17.9 percent over the 1973 base level will have its rate of increase limited to 17.9 percent. Prevailing charges that have increased by less than 17.9 percent will be unaffected. Any portion of the allowable increase not used will be carried forward to future years.

Because physicians are incorporating in increasing numbers, Internal Revenue Service data are no longer a good source of information about changes in physicians' office practice expenses, Weinberger said. Pertinent components of the Consumer Price Index, the Wholesale Price Index, Bureau of Labor Statistics wage indices, and data from Medical Economics were used instead.

HEW Secretary-Designate

F. David Mathews, 39-year-old President of the University of Alabama, has been selected by President Ford to be the new Secretary of the Health, Education and Welfare Department.

Incumbent Secretary Caspar Weinberger has said repeatedly in recent months he wished to return to California. He was not ousted from the post. His resignation is effective August 10, 1975.

Mathews is supposed to be more liberal than Weinberger whose chief forte was economy and rigid controls to effect economy. Completely unknown on the national political scene, the youthful University President has described himself as an independent. Rumor has it that he is at odds with Alabama Governor George Wallace.

A VOLUNTARY PROFICIENCY TESTING PROGRAM FOR GEORGIA

G. LESTER FORBES, JR., M.D., *Atlanta**

The Clinical Laboratory Act, Georgia Law 1970, contains an exemption from licensure and inspection of the laboratory work a physician performs in his office for his own patients. In September 1974, the Department of Human Resources presented to the Board of Human Resources a bill to amend this law, including an amendment to revoke the exemption for physicians' offices. At that time, the Board charged the Laboratory Licensure Division of the Department of Human Resources to survey the physicians in Georgia to determine how much and what type of laboratory work was performed in their offices, as well as what quality control or proficiency testing was being conducted. The Ad Hoc Committee on Laboratory Quality from the Medical Association of Georgia met with a committee from the Department of Human Resources to develop the format of a questionnaire which was mailed to half of the membership of the MAG in June 1975.

The Department of Human Resources is not the only government agency interested in laboratory procedures performed in physicians' offices. The Rules and Regulations of the Medicare-Medicaid program of the Department of Health, Education, and Welfare contain a provision to allow examination of physicians' offices at any time to assure quality of medical care. At the present time, Medicare-Medicaid does not have manpower for this on-site inspection of laboratory work.

The Committee on Laboratory Quality believes that legislation mandating participation in proficiency testing programs may be avoided by demonstrating that physicians who do perform laboratory procedures will voluntarily implement a proficiency testing program for their own offices. In April 1975, MAG's House of Delegates approved the committee's recommendation that MAG conduct such a program.

A number of programs providing physicians with the necessary materials for proficiency testing are available. Both the American Society of Internal Medicine and the College of American Pathologists have well-established programs designed for a physician's office. Each program provides participating physicians with specimens to be evaluated and returned to the central office. Statistics resulting from the values obtained from these specimens are returned to each participating physician so that he may be aware of the accuracy and precision of the laboratory procedures performed in his office.

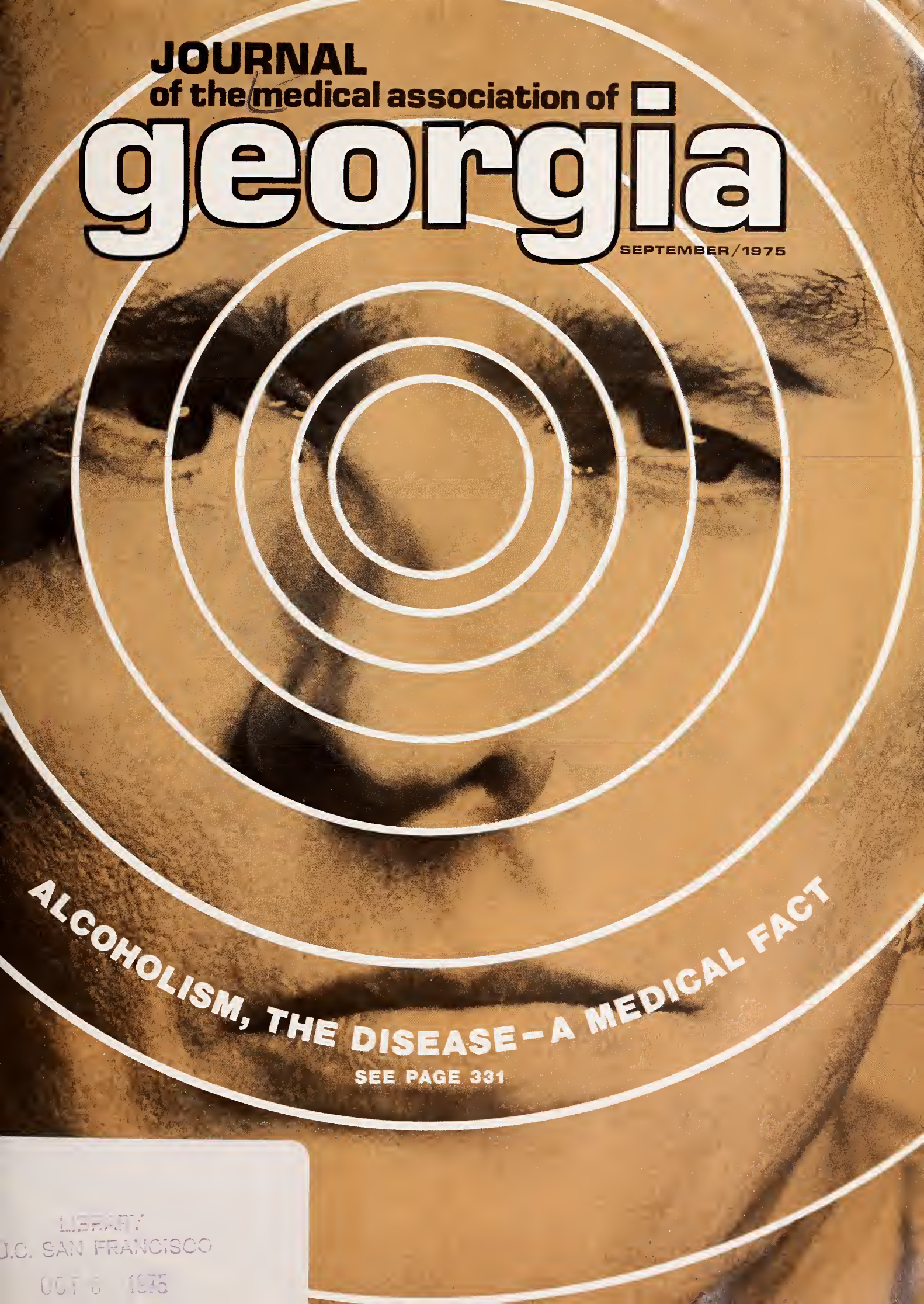
Each of these programs has a subscription cost which must be borne by the physician. The cost is proportional to the number of procedures he elects to monitor. In the early fall, physicians will receive information on these programs in separate mailings. While not endorsing any one program, the committee thinks that the partial test program of the American Society of Internal Medicine (Medical Laboratory Evaluation) is more appropriate for those physicians performing a minimum number of tests in their office. Similar information will also be received on the program of the College of American Pathologists (Proficiency Evaluation Program).

The committee believes subscription to these programs will make state legislation unnecessary. As part of the proposed voluntary program, the Medical Association of Georgia, with assistance from the Georgia Academy of Family Physicians and the Georgia Society of Internal Medicine, will review results of the programs, and, where difficulties are found, make recommendations to improve problem areas.

Each Georgia physician having laboratory procedures performed in his office is urged to participate in this voluntary proficiency testing program. A bill revoking the exemption of physicians' offices will certainly be introduced again during the next legislative session. A viable, voluntary program in the state of Georgia will provide the ammunition necessary to prevent its passage. ■

* Chairman, Ad Hoc Committee on Laboratory Quality. Dr. Forbes is a pathologist with offices at 340 Boulevard, N.E., Atlanta, Ga. 30312.

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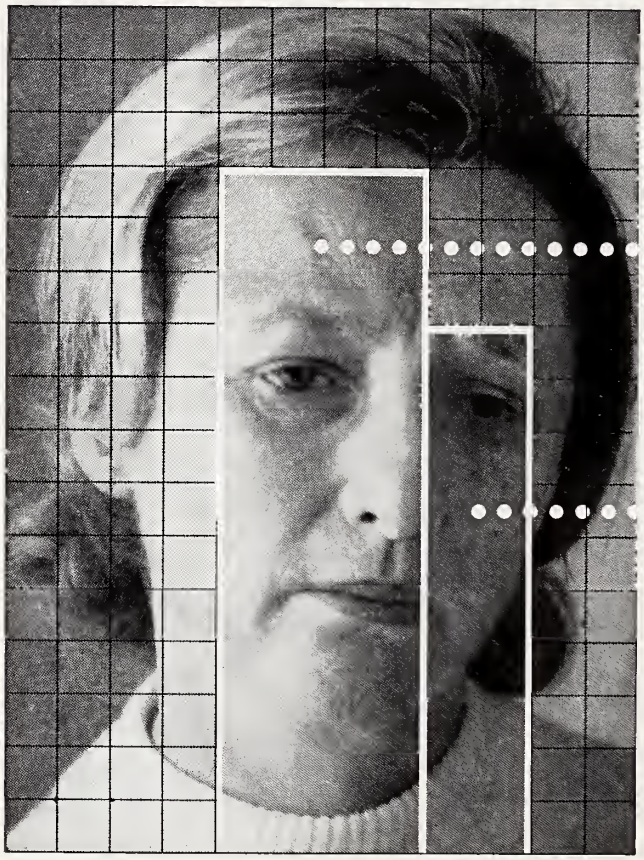


ALCOHOLISM, THE DISEASE—A MEDICAL FACT

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Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

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Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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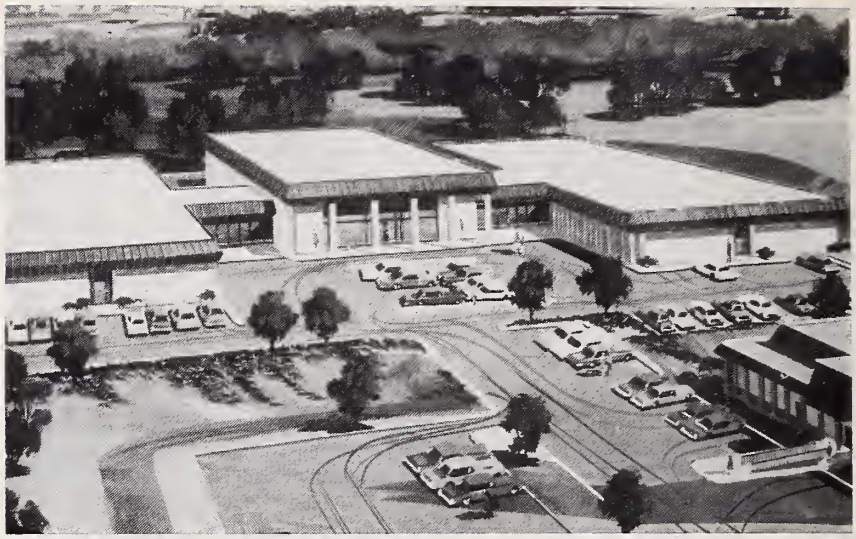
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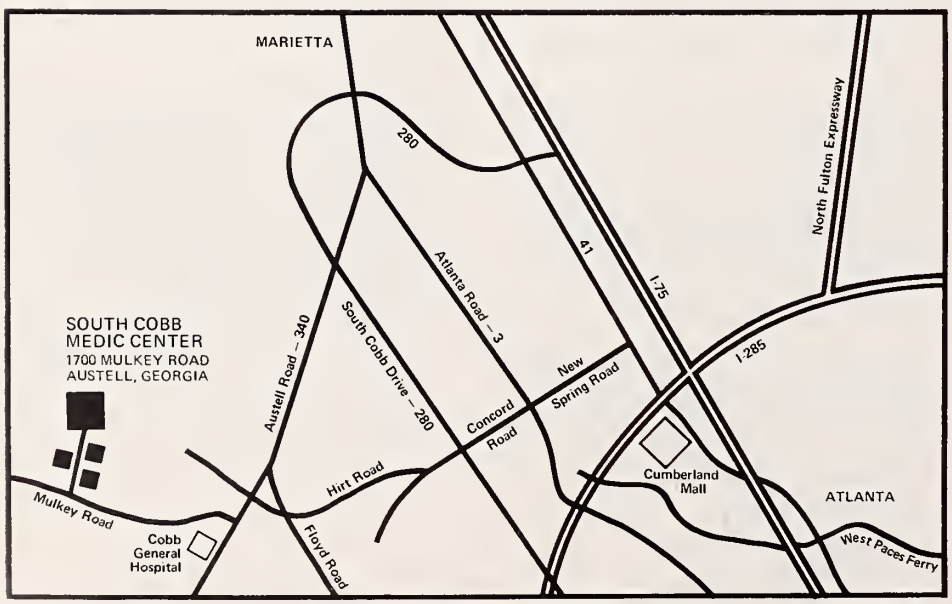


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Alcoholism the Disease—A Medical Fact

G. DOUGLAS TALBOTT, M.D., F.A.C.P., *and* OLIVIA GANDER, M.A., R.R.L., *Decatur**

THE GREATEST OBSTACLE encountered today in treating the alcoholic is the problem of attitudes. Though the American Medical Association, the American College of Physicians, and the American College of Psychiatry have all decreed that alcoholism be recognized as a disease, yet the vast majority of not only lay people but also professionals in the field of health care still regard this condition as either a symptom of a basic emotional disorder or simply a behavior problem ranking somewhere between deliberate sin and moral weakness. Such attitudes are apparent in the common patterns of professional treatment and of social contact, including family relationships. Successful treatment of alcoholism, like that of any other disease, is facilitated by early diagnosis; the prevailing attitudes prompt the alcoholic to deny and conceal his condition as long as he can, often with the connivance of both his family and his physician. Therefore it becomes important to examine both our own ideas about alcoholism and the evidence for regarding it as a bona fide disease.

Effects of Tradition and Prejudice

Traditionally we expect disease to be evinced primarily by such objective physical phenomena as abnormal changes in temperature, swelling, visible lesions, or other recognized signs of pathological process, as by such subjective symptoms as complaints of pain or weakness. So perhaps a prime reason why we have difficulty in accepting alcoholism as a disease is that its most obvious manifestations are acute intoxication and the abstinence syndrome, characterized by bizarre and often unacceptable behavior, all of which appears to be deliberately self-induced. Such behavior tends to arouse contempt and disgust.

One has to go back nearly three centuries to find comparable attitudes exhibited toward people who are ill. Syphillis of the central nervous system also produces bizarre behavior which at one time was observed with a mixture of fear and contempt, and in ignorance ascribed to possession by demons. At that time the etiology was unknown and the effect of syphillis on the central nervous system was wholly unsuspected; today the primary etiology of alcoholism is as yet unknown, and the mechanism of its action on the central nervous system is just beginning to be investigated.

As pioneers on the new frontiers of medicine explore the biochemistry and physiology of the central nervous system, scientists also investigate the effects of various drugs on the structure and function of that system, and behavior is beginning to be recognized as having a biochemical and physiologic as well as an emotional, psychiatric origin. Such studies encompass the effects of alcohol, for it must always be remembered that alcohol is a drug, and an addictive one.

Disease Criteria

In the traditional medical sense, a disease must meet certain criteria. It must be characterized by a group of identifiable signs and symptoms; it must follow a predictable and progressive course; it must produce some degree of anatomical alteration. Such is the general framework of disease; within it there are obviously various classes and subdivisions.

According to *Dorland's Medical Dictionary,* it matters not whether the specific etiology and full pathology of a disease are known, provided the other criteria are met. At present alcoholism shares the status of the other two most lethal diseases in our country (heart disease and cancer), in that its exact etiology is not known but must be presumed

* Dr. Talbott serves as Director and Ms. Gander is medical editor for the DeKalb Alcohol and Drug Programs, DeKalb-Georgian Clinic, 1260 Briarcliff Road N.E., Atlanta, Georgia.

to be multifactorial, and that our knowledge of its pathology is far from complete.

We are still in the infancy of our understanding of alcoholism, our country's third greatest health problem, yet undeniably obsolete is the historical premise that this is basically a psychiatric disorder. Modern research into the biochemical, hepatocellular, limbic, biophysical, and genetic factors involved, along with studies of the acetaldehyde cycle and the tolerance phenomenon, have destroyed the validity of a unilateral psychiatric approach.

Alcoholism Meets Disease Criteria

It has been clearly established that alcoholism presents a characteristic and identifiable group of signs and symptoms. Just as coronary occlusion cannot be diagnosed solely on the basis of chest pain alone, intoxication without other signs and symptoms is by no means a sufficient basis for the diagnosis of alcoholism; nor is the presence of any other single symptom sufficient for diagnosis. In the authors' experience and observation there is a constellation of seven major signs and symptoms which differentiate the "social drinker" from the alcoholic and confirm a diagnosis of addiction to alcohol. These are: First, compulsive, inappropriate drinking, with loss of control. Second, changing tolerance. Third, blackouts. Fourth, appearance of the symptoms of withdrawal after a few hours of abstinence. Fifth, destructive interference in the drinker's physical life and health. Sixth, destructive interference in his or her psychological life. Seventh, destructive interference in the socio-cultural life.

These seven signs almost always appear in concert, though confirming their presence may require considerable detective effort. For example, in response to the direct question, "Have you ever had withdrawal symptoms?" both the patient and his family may wrongly answer "No," simply because they equate withdrawal with delirium tremens and do not realize that the first stage of withdrawal may be manifested by anxiety, tremulousness, insomnia, or diaphoresis; and up to this point the alcoholic may have taken care that a drink prevented the development of further stages of withdrawal. The drinker may honestly not realize the significance of his blackouts, or his changing tolerance, or his need to always have a convenient bottle to comfort his restless nights. He may be totally unaware of the destructive manner in which alcohol is interfering with three major facets of his life; generally he attributes his increasing misfortune to other, more remote causes. But carefully purposeful questioning will usually elicit some manifestation of all seven diagnostic signs in a person suffering from alcoholism.

A major obstacle to clearly defining, recognizing, and ultimately accepting these seven signs is the fact that alcoholism, like syphilis, is a great imposter and masquerader. Its symptoms may be legion, depending on the organs affected by the progress of the disease, and it may mimic almost any disease entity. For example, it may be mistaken for gastritis whereas in reality the symptoms of gastritis may be produced by the disease of alcoholism. Thus its ubiquitousness and its varied manifestations have served to cloud and delay the recognition of alcoholism as a disease entity in itself.

Alcoholism follows a predictable, progressive, and irreversible course. The Jellinek chart,[1] and its numerous modifications as prepared by other workers, testify to the predictability and progressiveness of the disease. Case histories in our own experience, as well as those in the literature, testify to the irreversibility of alcoholism. When years, even decades, of abstinence are broken, even by what is intended to be a single drink, the compulsion of the drinking days returns, the last-experienced degree of tolerance re-asserts itself, and blackouts may resume almost immediately. The downward course continues, possibly even at an accelerated pace, and the period of abstinence is erased as though it had never been. Two examples come to mind. The first was that of a middle-aged musician who had been an active alcoholic in his youth but had been a total abstainer for more than 20 years. Then the band in which he played had an unexpected bit of good fortune and his buddies prevailed upon him to go with them to a tavern for a celebration. There he took his first drink in more than 20 years, immediately lost control, and a few days later came to the senior author in an advanced state of acute withdrawal. The gains for more than 20 years of careful sobriety had been lost in a brief time. The second example was the case of a widow in her late 60s, the mother of a young physician. She was an alcoholic who had stopped drinking about the time of the birth of her son and lived a useful, healthy life some 30 years, until the death of her husband. Thereafter, the grief of her loss and her slow, painful adjustment to her changed circumstances resulted in severe depression and insomnia. One night her son suggested an alcoholic concoction at bedtime to help her relax and sleep. Entirely unaware of her alcoholism, he himself prepared her drink and handed it to her, before he left her apartment. It was but the first of many drinks, and within the month

she became a hospital patient in an advanced stage of alcoholism.

One of the criteria of disease is that it produce some degree of anatomical alteration, as, for example, the obvious scars left by chickenpox and the better concealed scars resulting from pneumonia. Consistent anatomical alterations resulting from chronic use of alcohol have been recognized for decades. These were first noticed in the hepatic structure; for example, Jellinek devised a formula for determining the incidence of alcoholism, based on the presence of pathological changes in the liver. Since then, continued investigation with increasingly refined equipment and procedures have made possible the identification of changes in the structure of the central nervous system.[2] Changes have been detected at the cellular level of cardiac structures in autopsy studies of primary heart disease in alcoholics.[3, 4] There are reasons to believe that the continued ingestion of alcohol may affect the cellular structure of any organ of the body,[5, 6] though primary target areas are the heart,[7] central nervous system,[8] and the gastrointestinal tract.[9, 10]

Alcoholism as a Primary Disease

Alcoholism is a primary disease, a distinct clinical entity. It is not merely a symptom secondary to a psychiatric disorder, though the latter belief has historically governed most approaches to treatment. The basic fallacy in the purely psychiatric theory of etiology is that an overwhelming number of alcoholics were trapped in their disease because of the mores of their social group which decreed that social drinking is a sign of adulthood and of sophistication; they did not begin drinking to satisfy an infantile oral fixation or to compensate for emotional trauma suffered in childhood. In our society alcohol is not generally recognized as a dangerous, toxic, and potentially addictive drug, which it is; instead, it is considered a social and a ceremonial beverage, a harmless preparation, capable of alleviating tension and heightening the pleasures of social intercourse. Drinkers of all types, including even those who will ultimately exhibit the symptoms of alcoholism, first turn to alcohol primarily because of social custom, with no conscious desire for the pharmacological effects. Sooner or later the potential alcoholics are trapped within the tenacles of addiction and dependence, without ever realizing that they have been using and abusing a drug which has addictive properties. Even now this misconception about alcohol is demonstrated when parents say, "Yes, my son (or my daughter) does drink, but thank goodness he (or she) doesn't use *drugs!*"

Alcoholism, of course, is one form of addiction. So far we do not know why most people can drink reasonably, socially, or occasionally as they choose, while others inevitably lose control and ultimately develop all the characteristic symptoms of the disease, alcoholism. Until we do know what makes this difference, until we can establish the etiology of alcoholism, the assertion that alcoholism is a disease probably will continue to be challenged.

Only when and where the disease concept of alcoholism is fully accepted can we expect consistently improved results from treatment. Both the professionals who offer treatment and the alcoholic who is treated must constantly remember that alcoholism is a disease which is never "cured" but which can be arrested so that life again becomes peaceful, satisfying, and productive.

Summary

The greatest present obstacle to the successful treatment of alcoholism is that of attitudes, mind sets based on prejudice, rooted in tradition and lack of accurate knowledge, and resulting in a reluctance to fully accept the concept of alcoholism as a disease. When carefully considered, alcoholism fully meets the basic criteria of disease: it possesses a characteristic and identifiable group of signs and symptoms, it follow a predictable and progressive course, and it produces anatomic and physiologic alterations. Correct diagnosis and appropriate treatment are often delayed because misconceptions on the part of both the patient and his physician foster concealment. We cannot realistically expect earlier diagnosis or more effective treatment until attitudes are changed so that alcohol is generally recognized as a potentially addictive and lethal drug, and alcoholism is generally accepted, without qualification, as a medical disease. ■

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The method described is sufficiently simple and inexpensive to be carried out in most histopathology laboratories.

Cancer and Specific Red Cell Adherence Test

PAUL I. LIU, M.D., Ph.D., DOUGLAS H. McGREGOR, M.D., J. GRACE LIU, B.S. *and* ARMAND B. GLASMAN, M.D., *Augusta

In 1969, Davidsohn and his associates[1, 2] established a unique, simple and practical immunological technique called Specific Red Cell Adherence Test for the study of various cancer. Results obtained in these studies demonstrated complete loss of A, B and H isoantigens in invasive cancer and partial loss of A, B and H isoantigens in in-situ cases. This test is extremely valuable for assisting in the diagnosis of border-line cancer cases.

The natural history of carcinoma, on the basis of current knowledge of histopathology, can be divided into four stages: 1) carcinoma in-situ (sometimes preceded by a premalignant stage of dysplasia), 2) anaplastic carcinoma, 3) invasive carcinoma, and 4) metastatic carcinoma. Unfortunately, reliable histologic criteria for differentiating these stages in all cases are not yet available, and generally "the diagnosis of cancer still rests principally on the subjective impression of the pathologist."

In regard to carcinoma in-situ, many diagnosed cases do not progress to invasive carcinoma, and the diagnostic decision between carcinoma and dysplasia is frequently a matter of opinion. Consequently, some patients may be subjected unnecessarily to surgery and others may be deprived of the benefits of early surgery in cases which may progress to invasive carcinoma. Thus, more sensitive and more specific objective criteria are needed to permit a dependable diagnosis of early cancer. Similar problems arise in the diagnosis of anaplastic carcinoma, with the degree of anaplasia varying greatly and differences of interpretation being common. The histologic diagnosis of invasive carcinoma is less of a problem, unless the specimen is not a representative and does not include stromal tissue. The diagnosis of metastatic carcinoma, however, can seldom be made on the basis of histologic changes in the primary cancer. The unusual findings of vascular invasion may enable the pathologist to suspect the possibility of a metastasis, but even this is not dependable. Clinical findings of x-rays and radioisotopes may assist in the diagnosis of metastatic carcinoma, but usually this is possible only in advanced lesions, when the opportunity for successful intervention has frequently passed. If the pathologist could determine the probability of metastatic carcinoma by examination of the primary lesion, it would be of great prognostic and therapeutic benefit.

Tests, Methods Develop

The need for a more sensitive and more specific method of early diagnosis of carcinoma is clearly apparent. In view of the limitations of morphologic diagnosis and the high specificity and sensitivity of immunologic techniques in other fields of modern diagnostic methodology, many attempts have been made in the past to apply various immunologic procedures to the diagnosis of cancer. Considerable progress has been made during the past 40 years, with specific antigens being demonstrated in experimental cancer of animals and more recently in some forms of human cancer. The opposite approach was also tried, not searching for new specific antigens accompanying the newly developed neoplasm, but rather studying the effect of the developing cancer on antigens present in normal tissue. Understandably, the isoantigens A, B and H became objects for the study of the effect of carcinoma on normal tissues because they are present and easily detected in erythrocytes of blood groups A, B and O, in some body fluids, and in various tissues.

The earliest technique for the demonstration and

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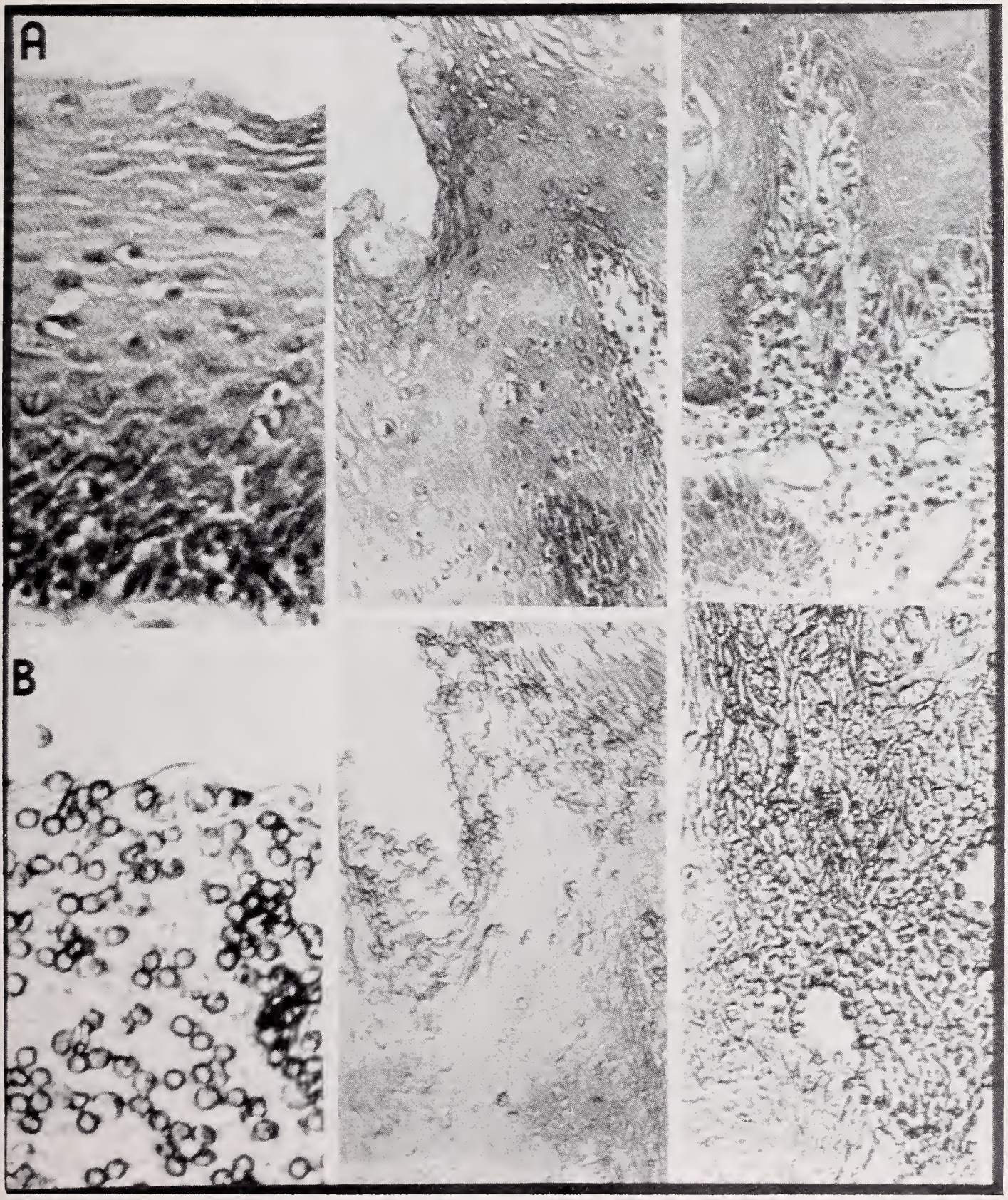


FIGURE 1

A. Tissues stained with Hematoxylin and Eosin stain (upper half) (from left to right) normal, carcinoma in-situ and invasive carcinoma. B. Same tissue showing SRCA reactions (from left to right): positive, partial positive, and negative. (Complete absence of red cell adherence, except three blood vessels demonstrate adherence of red cells to endothelium, acting as built-in positive control.)

identification of the three antigens in tissues was the agglutination inhibition test.[3] Human sera containing the corresponding anti-A and anti-B isoantibodies were absorbed from tissue extracts or suspensions. Utilizing immunofluorescence and immunoperoxidase staining methods, A and B isoantigens were demonstrated in paraffin sections of formalin-fixed normal tissues. A modification of Coombs' mixed agglutination was exclusively used by Davidsohn and associates and the designation of the test was changed to "Specific Red Cell Adherence Test" because it fitted better in the actual appearance of the reaction in the tissues.

In-depth study of cancer using specific red cell adherence test (SCRA Test) were performed by Davidsohn (cancer of cervix, lung, pancreas and stomach)[1, 2] and Liu (cancer of oral cavity and larynx).[4-6] Complete or almost complete loss of isoantigens was demonstrated in invasive cancer and partial loss of isoantigens in in-situ cases compared with examples of normal tissues none of which showed loss of isoantigens. (Figures 1 and 2)

The technique of the SRCA test, a modification of the methods of Coombs,[7] involves a "sandwich" type of reaction and was developed by Davidsohn.[2] The bottom layer is the tissue section, the top layer is the indicator erythrocytes, and the middle layer holding the top and bottom together is the specific antiserum anti-A or anti-B, or the lectin *Ulex europeus*. Reagents used included commercially available pooled, natural human antisera from blood donors which were used for detection of A and B isoantigens with the SRCA test. Agglutinin titers varied from 256 to 512. Citrated blood of groups A, B and O were washed and the red blood cells resuspended in Tris buffered saline to a 1 per cent concentration. Microscopically, a positive SRCA reaction is seen as a uniform distribution of the indicator erythrocyte over the tissues having the corresponding isoantigen.

SRCA Technique

Details of the SRCA technique have been described previously by Davidsohn[8] and Liu,[9] however, this will be briefly quoted below:

1. Deparaffinize paraffin section or frozen section, 5 μ in thickness.
2. Wash tissues with Tris buffered saline (TBS) for five minutes.
3. Wipe excess TBS from slide.
4. Cover tissue with three drops of antiserum in moist chamber in room temperature for 15 minutes.
5. Remove non-binding antibody by washing tissue in TBS, three times for 15 minutes, each.
6. Wipe excess TBS from slide.
7. Cover tissue with three drops AB or fetal calf serum, in moist chamber, in room temperature for five minutes. (This prevents nonspecific adherence of RBC to the glass.)
8. Add three drops of a 1 per cent RBC suspension on top of the AB serum for 10 minutes.
9. Upside down slide on surface of TBS.
10. Observe under light microscope.

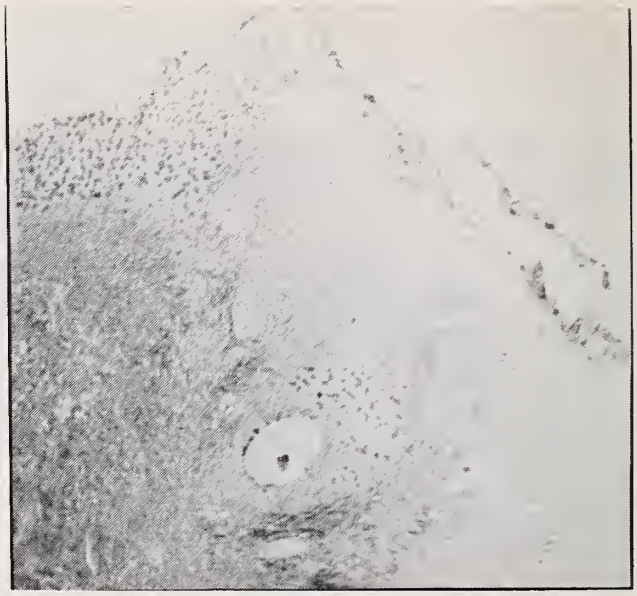


FIGURE 2

Early invasive squamous carcinoma of larynx, showing transitional change of SRCA test from positive (left) to negative (right) reaction; representing transition of normal squamous mucosa to carcinoma. An area of partially positive SRCA test reaction is noticed within the carcinomatous lesion (X 100).

The method used in the SRCA test is sufficiently simple and inexpensive to be carried out in most histopathology laboratories. Furthermore, any frozen or formalin-fixed, paraffin-embedded tissue is suitable, regardless of how many years previously the specimen was removed from the patient. The several built-in positive and negative controls are another advantageous feature. Thus, the SRCA test is highly recommended to assist in the diagnosis of questionable border cancer cases. ■

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MAG MEMBER ORGANIZES COMMITTEE TO AID VIETNAMESE PHYSICIAN-REFUGEE

Atlanta psychiatrist Stephen W. Edmondson is spearheading a drive to help a Vietnamese physician and his family who have come to Atlanta. He wants to help them start up housekeeping and begin the lengthy process that would enable the doctor to practice medicine again.

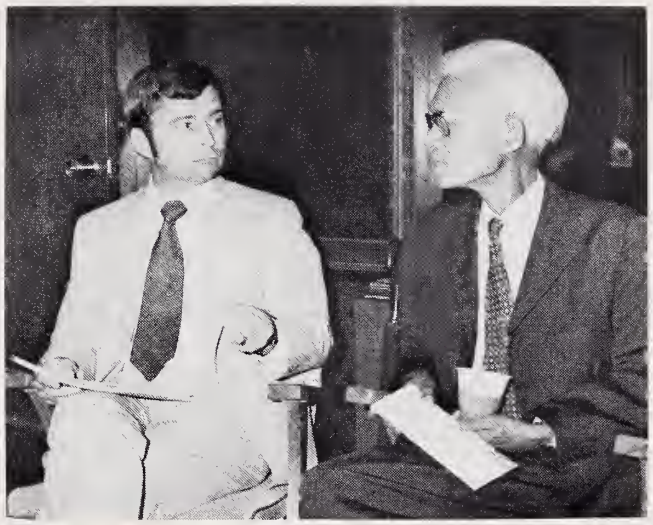
Dr. Edmondson, who served in Vietnam in 1968 and 1969 as a medical officer in the Third Marine Division, hopes to interest enough Georgia physicians, at least 10 to 15, in joining a "committee" which would spread the financial involvement and responsibility among many. Dr. Cung Hong Vu, his wife and several members of her family (parents, brothers and sisters) escaped South Vietnam April 27, two days before the fall of Saigon. They were transported to Guam, then finally to Ft. Chaffee, Arkansas where they were living until definite arrangements were made for them to come to Atlanta August 21. The family of 10 needs housing, clothing, furnishings, but most importantly sources of income and education.

Dr. Vu, taught English by the French as many Vietnamese were, reads and speaks English but would need to build up his proficiency. He hopes to find a position as an assistant in a physician's office to help him prepare to take the necessary steps and examination for his own licensure. Initially, the opportunities of a large city might be most useful to him, Dr. Edmondson says, but Dr. Vu may move to one of Georgia's rural communities eventually.

Those physicians serving on the committee Dr. Edmondson will establish would be asked to contribute only $25 per month each for about six months. These funds would cover basic living expenses for the family, which, like other refugee families, is eligible for food stamps and Medicaid. These benefits were granted by Presidential order to ease the burden on the states in which they settle. Also needed would be medical volumes and equipment and reference books for Dr. Vu's study.

Dr. Vu was born in North Vietnam and is 37 years old. He fled with his family to South Vietnam in 1954, attended a Catholic French high school and received his degree from the Faculty of Medicine in Saigon in 1966. He then was graduated from the Military Medical School in 1966 and served in the armed forces as a family physician. His 26 year old wife was a third year pharmacy student, and her brothers and sisters, ranging in age from 14 to 24, attended high school and college, where two were medical students. Mrs. Vu's parents also are with them and are 53 and 57.

Dr. Edmondson learned of this physician and his needs indirectly by coming in contact with Dr. Vu's older sister and brother-in-law already settled in Atlanta. The Vietnam veteran read an article in the July 3 *Atlanta Constitution* concerning the Chau family who had arrived in Atlanta. Through some mixup, they



Dr. Edmondson and Le Duy Chau discuss plans to provide for Dr. Vu's family.

now had no sponsors and needed help badly. The head of the family, Le Duy Chau, 60, was the former Minister of Social Services in South Vietnam for 20 years, and was instrumental in helping with the evacuation of so many orphans in the last months. His family fled as Saigon fell, was transported to Guam, then Eglin Air Force Base in Florida, and arrived in Atlanta June 26. The 13-member family has been receiving temporary help from Friends of Children, Inc., an international charitable organization, which was appealing for churches and individuals to join in the effort at the time the newspaper story attracted the attention of Dr. Edmondson.

The family has been housed in a Moreland Avenue home the organization planned to use as a halfway house for refugees. They had been supplied with most of the basic needs, but lacked enough chests and dressers, plus winter clothing will be needed soon. A garden was started and the family began making arrangements for schooling and jobs. One son, interestingly, found a job in a Cuban restaurant.

Dr. Edmondson responded to this plea for more help, and took the request to his own church, St. Martin in the Fields Episcopal, finding the members eager to do something concrete for refugees. After talking with the Chau family, Dr. Edmondson learned that Dr. Vu and his wife's family needed help in coming to the city, too.

One of Dr. Edmondson's first steps was to contact fellow physicians in the Atlanta area who had served in Vietnam, too, and would be most sympathetic to the proposed committee. Any and all MAG members are encouraged to help. For additional information, contact Dr. Edmondson at (404) 294-9060, 5064 Nandina Lane, Dunwoody, Georgia 30338.

A brief description of reports currently being generated from the 1973 birth records with some indication of the possible uses of the information contained on the certificate.

The Georgia Birth Reporting System: Current Reports and Potential Applications

G. E. ALAN DEVER, Ph.D. *and* CHARLES M. PLUNKETT, *Atlanta**

RECORDS OF BIRTHS have long provided health planners with valuable information. Based on the number of births, we are able to describe a component of population growth and relate this component to projections of such items as total population and school enrollment. Coupled with information such as age and race of mother, we are able to examine a wide range of fertility measures for a population. With the inclusion of confidential medical information concerning pregnancy and birth, implemented in the 1973 Certificate of Live Birth, we have available to us the possibility of extensive biostatistical analyses relating the outcome of the pregnancy to the mother's medical history.

The purpose of this article is to give a brief description of reports currently being generated from the 1973 birth records, and to provide some indication of the possible uses of the information contained on the certificate. In doing so we hope to impress upon the reader two things. First, the availability of information which provides the opportunity to evaluate the effectiveness of programs designed to influence the outcome of a pregnancy and second, the need for preparing the confidential portion of the certificate accurately and completely.

Reports Now Generated

Currently, several reports are generated from the birth records by the Health Services Research and Statistics Section in the Division of Physical Health. Along with the annual Vital Statistics, reports are available showing the relationship between the mother's age, race, education and prenatal history, and the incidence of complications of pregnancy and childbirth, congenital malformations, birth injuries,

TABLE 1

CERTIFICATE OF BIRTH REPORTS,* BY CATEGORY, FREQUENCY AND GEOGRAPHIC AREA

Category	Geographic Area		
	State	Service Area	County
Total births by weight ...	Q, A	Q, A	Q, A
Live births by weight	Q, A	Q, A	Q, A
Fetal deaths by weight ...	Q, A	Q, A	Q, A
Premature births	Q, A	Q, A	Q, A
Births to mothers			
Under age 18	Q, A	Q, A	Q, A
Over age 35	Q, A	Q, A	Q, A
Births to unwed mothers .	Q, A	Q, A	Q, A
Time between pregnancies	A	A	A
Births by age and gravidity of mother ...	A	A	A
Births by age and parity of mother	A		A
Birth injuries or diseases of child	A		A
Pregnancy complications .	A		A
Complications not related to pregnancy	A		A
Complications of labor ...	A		A
Method of delivery	A		A
Congenital malformations	A		A

Frequency: Q = Quarterly, A = Annually.

* Reports are by race, and reflect both numbers occurring and rates per 1,000 live births.

Source: Health Services Research and Statistics, Division of Physical Health.

* Dr. Dever is director and Mr. Plunkett is research assistant for the Health Services Research and Statistics Section of the Division of Physical Health, Georgia Department of Human Resources, 47 Trinity Ave., S.W., Atlanta, Ga. 30334.

prematurity, low birth weight, and fetal deaths. These characteristics allow us to identify high risk factors involved in pregnancy and childbirth, and at the same time to report the incidence of each occurrence for the state, service areas, and counties. Reports are based on births over 500 grams, live births, and total births. Table 1 provides a representative sample of the reports currently available. It is not an exhaustive listing, and does not reflect the many special reports that are generated each year.

As examples of the current reporting system output, several tables of selected categories have been included in this report. Table 2 reports births to unwed mothers by race, by place of occurrence and attendant. Table 3 shows specified birth statistics, including number of births, fetal deaths and length of time between pregnancies. Table 4 displays for the state the number of congenital malformations identified at birth. Of particular significance is the number of "unknowns" occurring. As there is no "unknown" category allowed for in the congenital malformations portion of the certificate, the 9,000 unknowns represent 9,000 birth certificates which had this portion left completely blank.

A second use of the information contained on the birth certificate is in conjunction with programmatic areas that are required to identify the handicapped infant and medically high-risk infant population. For example, a tabulation of all birth injuries and congenital malformations could be supplied to the Crippled Children's Unit, listing the newborn clients to be serviced by the program. Similarly, a report of other conditions of the child

TABLE 2

LIVE BIRTHS TO UNWED MOTHERS BY RACE OF INFANT, PLACE OF OCCURRENCE AND ATTENDANT, 1973 BY SELECTED GEOGRAPHIC AREAS

County Name	Race	Hospital					Other				
		Total	Physicians	Midwives	Nurse-Midwives	Other	Total	Physicians	Midwives	Nurse-Midwives	Other
State totals	White	2,022	1,887	2	32	101	21	11	2		8
	Black	9,177	8,643	9	225	300	299	75	180	10	34
	Other	10	9		1						
Appling	White	7	7								
	Black	27	27								
	Other										
Atkinson	White	3	3								
	Black	12	12								
	Other										
Bacon	White	7	6			1					
	Black	11	8			3					
	Other										
Baker	White	2	2								
	Black	7	6			1					
	Other										
Baldwin	White	8	7			1					
	Black	77	72			5					
	Other										
Banks	White	2	2								
	Black	1	1								
	Other										
Barrow	White	2	2								
	Black	18	17			1					
	Other										
Bartow	White	22	22								
	Black	17	15			2					
	Other										
Ben Hill	White	4	3			1					
	Black	53	45		1	7					
	Other										
Berrien	White	3	3				1	1			
	Black	13	13								
	Other										
Bibb	White	53	52			1					
	Black	457	454			3	1				1
	Other	1	1								

Source: Health Services Research and Statistics, Division of Physical Health.

existing at birth could be provided to appropriate programs.

Evaluating Family Planning

The third, and potentially most important use of the birth record is the opportunity provided for the evaluation of the effectiveness of programs designed to influence the outcome of pregnancy. Two possible programs are Family Planning and the Maternal High Risk Package (MAT-PAK). Both programs are designed to influence pregnancy and childbirth. Family planning, in addition to the obvious goal of preventing pregnancy, also is concerned with providing services to those women desiring children. In relation to this objective, by linking the birth record to the Family Planning participants, it would be possible to determine if the prenatal services and counseling provided by the program were having a beneficial effect. In addition, it would be quite easy to provide the Family Planning Unit with a list of former clients in order to re-enter them into the program.

The MAT-PAK program is designed to aid mothers who have certain factors of maternal high risk and are defined as medically indigent. By linking the MAT-PAK records with records of births and neonatal and maternal deaths, we can evaluate whether in fact the program has succeeded in affecting the outcome of pregnancy. We can get answers to such questions as: Have we reduced the incidence of birth injuries? Have we succeeded in lowering the fetal, neonatal and maternal death rates for the subject population? And finally, is the program effective in accomplishing its goal? Similarly, the birth records could be linked to other programs to determine program effectiveness.

It must be emphasized that all of this information depends on accurate *completion* of all portions of the birth certificate. A study of the birth records for 1973 has indicated a high incidence of certificates which have not been fully completed. This leads to problems with the validity of reports based on the birth records.

Clearly, properly completed birth certificates, both in themselves and linked to other programs, will provide quality information for planning purposes and for evaluating program effectiveness. ■

TABLE 3

SPECIFIED BIRTH STATISTICS FOR BIRTHS OVER 500 GRAMS, 1973, STATE TOTALS

					Rate Per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Total births over 500 grams	96,148	62,829	32,754	565	1,000	1,000	1,000	1,000
Total births over 1000 grams	95,522	62,575	32,384	563	993	995	988	996
Total births over 2500 grams	78,368	52,597	25,239	532	815	837	770	941
Live births over 500 grams	85,069	55,883	28,621	565	884	889	873	1,000
Live births over 1000 grams	84,702	55,726	28,413	563	880	886	867	996
Live births over 2500 grams	77,789	52,251	25,006	532	809	831	763	941
Premature total births over 500 grams	19,854	11,776	8,031	47	206	187	245	83
Premature total births over 1000 grams	19,228	11,522	7,661	45	199	183	233	79
Fetal deaths over 500 grams	11,079	6,946	4,133		115	110	126	
Fetal deaths over 1000 grams	10,820	6,849	3,971		112	109	121	
Fetal deaths over 2500 grams	579	346	233		6	5	7	
Unwed mothers	18,812	6,447	12,355	10	195	102	377	17
Under 1 year between last live birth or last fetal death	3,658	2,170	1,454	34	38	34	44	60
12-18 months between last live birth or last fetal death	6,022	3,282	2,688	52	62	52	82	92
Over 18 months between last live birth or last fetal death	60,785	48,898	11,685	202	632	778	356	357
No prenatal care	13,907	9,330	4,500	77	144	148	137	136
Mother under 18 years old	12,201	5,895	6,283	23	126	93	191	40
Mother over 35 years old	3,199	1,937	1,240	22	33	30	37	38
Mother over gravida 4	5,413	2,202	3,193	18	56	35	97	31

Source: Health Services Research and Statistics, Division of Physical Health.

TABLE 4

CONGENITAL MALFORMATIONS IDENTIFIED AT BIRTH, FOR BIRTHS OVER 500 GRAMS, 1973, STATE TOTALS

	Total	White	Black	Other	Percent of Malformations Total	White	Black	Other	Percent of Total Births Total	White	Black	Other
None	77,808	51,857	25,433	518	.00	.00	.00	.00	88.05	88.79	86.53	90.71
Anencephaly	40	31	9		3.61	4.02	2.71	.00	.04	.05	.03	.00
Spina bifida	65	49	16		5.86	6.35	4.81	.00	.07	.08	.05	.00
Hydrocephalus	65	52	13		5.86	6.74	3.91	.00	.07	.08	.04	.00
Cleft lip and/or palate	120	91	28	1	10.83	11.80	8.43	20.00	.13	.15	.09	.17
Cardiovascular anomaly	79	54	24	1	7.12	7.00	7.22	20.00	.08	.09	.08	.17
Musculoskeletal anomaly	53	33	20		4.78	4.28	6.02	.00	.05	.05	.06	.00
Gastro-intestinal anomaly	185	127	56	2	16.69	16.47	16.86	40.00	.20	.21	.19	.35
Down's syndrome	40	32	8		3.61	4.15	2.40	.00	.04	.05	.02	.00
Other	461	302	158	1	41.60	39.16	47.59	20.00	.52	.51	.53	.17
Unknown	9,444	5,772	3,624	48	.00	.00	.00	.00	10.68	9.88	12.33	8.40
Total malformations	1,108	771	332	5	100.00	100.00	100.00	100.00	1.25	1.32	1.12	.87

Source: Health Services Research and Statistics, Division of Physical Health.

EDUCATION EXPERT TO ADDRESS MAG SCIENTIFIC ASSEMBLY

Anne R. Somers, a distinguished author, lecturer, teacher and health care administrator, will deliver the principal address at MAG's 1975 Scientific Assembly, to be held November 21-22 at the Terrace Garden Inn in Atlanta. Mrs. Somers will speak at the Assembly's opening luncheon for all physicians and their wives. She is singularly qualified to address her topic—"Current Issues in Health Education."



Mrs. Somers has been continuously engaged for over two decades in health care studies and activities. She is the author of *Health Care in Transition: Directions for the Future* (1971), and *Hospital Regulation: The Dilemma of Public Policy* (1969), and co-author with her husband of *Medicare and the Hospitals* (1967), *Doctors, Patients, and Health Insurance* (1961), and *Workmen's Compensation* (1954). She is editor of *The Kaiser-Permanente Medical Care Program* and author of over a hundred additional articles and monographs.

An honorary Doctor of Science degree was bestowed upon Mrs. Somers in 1975 by the Medical College of Wisconsin, and she is presently associate professor in the Departments of Community Medicine and Family Medicine at the College of Medicine and Dentistry of New Jersey-Rutgers Medical School. She was founder and first Director of CMDNJ's Office of Consumer Health Education and serves as a member of numerous organizations, including the National Academy of Sciences, the American Board of Medical Specialties, and the Advisory Committee on Health Services of the Association of American Medical Colleges.

During 1970 and 1971 Mrs. Somers served as coproducer and scriptwriter for two television films produced by the New Jersey Public Broadcasting Authority: "The Hospital and The Community" and "The Hunterdon Medical Center—One Community's Approach to Comprehensive Health Care."

In addition to addressing MAG's entire Scientific Assembly, Mrs. Somers will participate in one of its sections as a panelist at the scientific program sponsored by the American College of Physicians (Georgia) on November 21. On the following day she will participate in a public education session sponsored by the Georgia Diabetes Association.

Abdominal Pain With a Left Lower Quadrant Calculus

VAN COLEMAN, M.D. *and* PAUL HUTCHINSON, JR., M.D., *Atlanta**

DR. VAN COLEMAN: These are the films of the abdomen on an 83-year-old female who presented with a 24-hour history of progressive anorexia, nausea and vomiting, and crampy abdominal pain. Physical examination revealed abdominal distention with intermittent peristaltic rushes. Dr. Hutchinson, would you discuss this case?

Dr. Paul Hutchinson: The films of the abdomen (Figure 1) show distended small bowel loops consistent with the diagnosis of mechanical obstruction. There is a laminated calcific density in the left lower abdomen, overlying the pelvic inlet (Figure 2). There also appears to be a calcific density in the right upper quadrant, having the appearance of gallbladder calculus.

Upright films fail to demonstrate evidence of free air in the peritoneal cavity. There is no evidence of abnormal gas shadows in the region of the biliary tree.

Dr. H. S. Weens: What are the pertinent findings on these films?

Dr. Hutchinson: The pertinent findings are distended loops of small bowel compatible with mechanical obstruction, evidence of a calculus in the gallbladder area and a similar calculus in the left lower abdomen. These findings would indicate mechanical small bowel obstruction secondary to a gallstone which has been extruded from the biliary tract into the intestine with obstruction of the distal ileum secondary to spastic ileus—a gallstone ileus.

The diagnosis may be proved by barium enema with reflux into the ileum and demonstration of the stone or upper gastrointestinal study to demonstrate the fistulous tract from the biliary tree to the gastric antrum or duodenum, the most common sites of extrusion.

Dr. Coleman: Contrast studies were not carried out. The patient underwent abdominal surgery and a gallstone was found obstructing the ileum, approximately 30 cm. from the ileocecal valve. A fistulous communication between the gallbladder and the duodenum was also found at surgery.

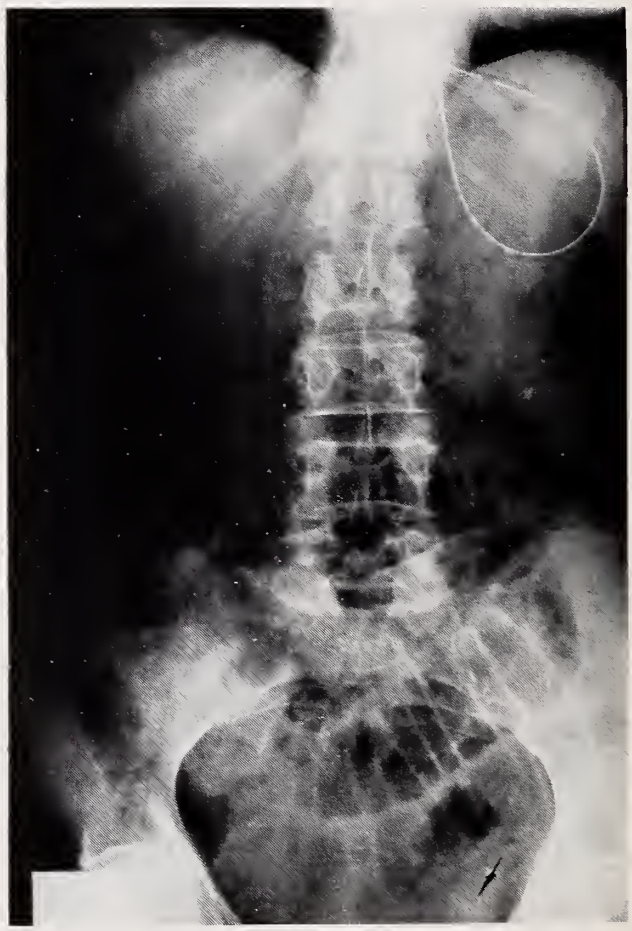


FIGURE 1

Recumbent film of the abdomen demonstrating distended small bowel loops and laminated calculus on the left side of the pelvic inlet.

Dr. Weens: One of the classic radiographic findings which is listed in the literature is the presence of air in the bile duct system. This patient does not exhibit that finding. It has not been emphasized in the literature that this is not always the case. The

* From a weekly X-ray Conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material was edited by Drs. J. L. Clements and H. S. Weens.

majority of patients with gallstone ileus exhibit what we have here. The absence of air in the biliary system should not keep you from making the diagnosis of gallstone ileus.

Discussion

The present case is a fairly typical example of gallstone ileus, an entity which is characterized by mechanical bowel obstruction secondary to an impacted gallstone. Gallstones gain entrance into the gastrointestinal tract most often by perforation into the duodenum, hepatic flexure of the colon, or stomach, and the most common site of obstruction is the distal small bowel. It is a relatively infrequent occurrence developing in a 0.3 to 0.4 per cent of those with gallstones and accounting for 0.4 to 5 per cent of all cases of small bowel obstruction.

Clinically, the symptoms are nonspecific and, in general, indistinguishable from those of small bowel obstruction of any type, but a previous history of gallbladder disease and the increased incidence in the older age group and in women may provide a clue to the diagnosis. Radiographically, the following triad of findings on plain films of the abdomen often allows one to make the diagnosis preoperatively: 1) a small bowel obstructive pattern, 2) air in the biliary tree and 3) visualization of the stone in the intestinal tract. Unfortunately, the presence of all three findings is unusual, and if only one or two of the triad is demonstrated, contrast studies of the intestinal tract may be useful in confirming the diagnosis. ■

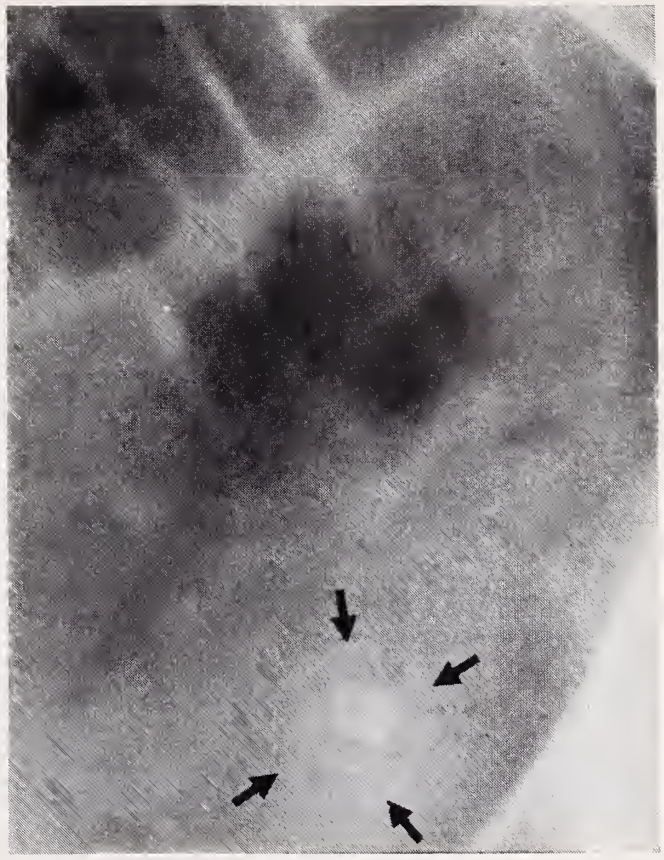


FIGURE 2

Detail of the laminated calculus (gallstone) on the left side of the pelvic inlet.

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GROUNDBREAKING CEREMONIES HELD FOR NEW ST. JOSEPH'S INFIRMARY

Groundbreaking ceremonies for the new $30 million St. Joseph's Infirmary on Peachtree Dunwoody Road at Johnson Ferry Road in north Atlanta were held in August with U.S. Senator Herman E. Talmadge the featured speaker.

Rawson Haverty, chairman of St. Joseph's Board of Trustees, presided over the ceremonies. Also officiating for this event in the history of Atlanta's oldest hospital, founded by the Sisters of Mercy some 100 years ago, were Catholic Archbishop Thomas A. Donnellan and Sister Mary Brian, hospital administrator. MAG members who served on the Board of Directors are Duncan Shepard, M.D., chief of surgery; Robert Mabon, M.D., neurosurgeon; William A. Hopkins, M.D., chief of cardiothoracic surgery; and William F. Friedewald, chief of staff.

Sen. Talmadge told the audience he was preparing legislation to tighten up and eliminate widespread weaknesses in the Medicaid and Medicare programs. He explained that he seeks to increase control over the programs by combining them under one new division in the Department of Health, Education and Welfare. He pointed out that these government medical programs are not delivering the speedy and reliable medical care envisioned by the lawmakers nearly 10 years ago at their inception.

St. Joseph's also has recently received accreditation by the Joint Commission on Accreditation of Hospitals (JCAH), after an on-site survey made by field representatives of the JCAH. The hospital thus becomes one of approximately 5,300 general hospitals throughout the U.S. to earn this recognition out of a total of some 7,400 hospitals in the nation.

editorials
editorials
editorials

Close Ties With MAG Strengthens Efforts of Specialty Societies

IN THE 20 YEARS from the end of World War II in 1945 and the advent of Medicare in 1965, there was a rise in the number of specialists and consequently the development of specialty societies which tended to fragment organized medicine. A general lack of concern for the overall practice of medicine and its related problems developed and was accompanied by a growing self-interest concern for the delivery of health care in the physician's chosen specialty. Coinciding with the rising specialization was the education of the populace so that the terms gynecologist, pathologist, otolaryngologist, neurologist, etc. became words not unknown in the average household. The shadowy mysticism of medicine fell abruptly as our TV heroes dispatched problem after problem in a half hour's time. Medicine suddenly was faced with the "need" for better health care delivery and the "need" for progression, for there was no such thing as the art of medicine. It could be delivered cookbook style as noted on the TV screen.

Thus, in the last decade as the pendulum swung towards family medicine, external forces were developing; state and federal regulations, changing codes in "health care providers," the inundation of medicine with assistants, and all before one could realize the definite trend of change. Unfortunately, all change isn't progress and rapid delivery of health care isn't necessarily equated with quality. With increased government intervention and regulations, it becomes acutely obvious that specialists and their societies need to re-evaluate their relationship to organized medicine, if for no other reason than their own survival. Some 4,200 Medical Association of Georgia physicians bring a better response than the volume of 200 voices in a specialty society.

In the April issue of the *Journal of the Medical Asociation of Georgia,* an editorial by the past president of the Georgia Society of Ophthalmology brings to light typical legislation that is being fostered for the sake of "progress" and to "improve the delivery of health care." Although this legislation affected our specialty more directly, it would have served as a vehicle for other non-physician practitioners to undermine other fields of medicine in the future. Defeat of this legislation this year was accomplished only with great effort by the combined forces of the Medical Association of Georgia and the Georgia Society of Ophthalmology. House Bill 88 will be revised in the 1976 session and will again require a concerted effort by organized medicine for its defeat.

Working Against Optometry School

Last month, the Board of Regents took under advisement consideration for the development of a school of optometry in this state. The Medical Association of Georgia, the Georgia Academy of Family Physicians and the Georgia Society of Ophthalmology joined hands to bring to the attention of this body the inaccuracy of the information they had received and the lack of need for such a school. This program would have severely crippled the funds needed to expand and complete the existing programs for the development of family practice at the Medical College of Georgia. The presentation of the material to

this group by the combined societies was impressive and hopefully will scuttle this unfortunate proposal. The development of this school at the Medical College of Georgia would have created a non-physician school on an academic level with dentistry and medicine at a major medical center. This would have been followed by a demand that the legislature change the optometric code allowing them to practice "non-major" surgical medicine. Far fetched? Read the bill before the Alabama legislature allowing optometrists to practice what is taught in the Alabama School of Optometry at the University of Alabama Medical Center.

The diligent efforts of the Medical Association of Georgia through its Council, staff and GAMPAC in helping us provide a solid front from organized medicine in opposition to this legislation has rekindled our desire to be more closely aligned with the Medical Association of Georgia in all activities. All specialty societies would benefit by a closer union with the Medical Association of Georgia. Joining the scientific programs in November; helping out with the lobbying efforts by contacting legislators in one's own district; are ways in which these societies can strengthen their ties with the Medical Association of Georgia as we gear for the malpractice issue and the federal and state legislation which affects all physicians in their individual practice. We must all back the family physician as the primary health care provider and we cannot afford to allow our legislators to relegate this authority to lesser trained assistants and practitioners who are so anxious to assume this role. We realize that to obtain renewed confidence in medicine we must maintain closer ties with organized medicine and to properly give input to the Medical Association of Georgia.

S. Fleetwood Maddox, M.D., President
Georgia Society of Ophthalmology
800 First Street
Macon, Georgia 31201

HIGHLIGHTS OF EXECUTIVE COMMITTEE
Sunday, August 17, 1975

Composite State Board of Medical Examiners: Received the report that Cecil L. Clifton has replaced William J. Morton, M.D. as Executive Director.

DHR Office of Public Health Education: Supported the recommendation of the MAG Subcommittee on Public Health Education that this new office be established in the DHR.

Medicaid Reimbursement by Specialty: Heard a report that the Director of Program Services of the DHR is seeking MAG guidance in developing guidelines for determining payment profile for physician specialties. Referred this request to the Interspecialty Council.

"Disabled Doctors" Plan: Heard a report presented by G. Douglas Talbott, M.D., which described the not widely recognized problem of physicians with alcohol, drug abuse or psychological difficulties. The plan, which has demonstrated some success in six other states, presents numerous ways of coping with the problem. The Executive Committee approved the plan and referred it to Council for adoption.

SEER: Endorsed the proposal submitted by Emory University. Executive Committee will receive periodic reports of the progress of the program.

Committee on Maternal and Infant Welfare: Adopted the report of the Committee which endorsed changes in the minimum standards for maternity and newborn facilities. Commended the Committee for its efforts.

Interspecialty Council: Approved guidelines for representation on and the activity of the Interspecialty Council.

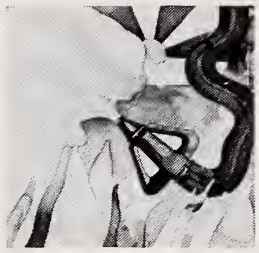
Survey of the Utilization of P.A.'s: Approved an expenditure of $100 to provide a data processing consultant to the Ad Hoc Committee to Study Physician's Assistants to determine the feasibility of a survey on the use of P.A.'s by primary physicians.

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Changing Concepts in Surgery for Cancer

SAM A. WILKINS, JR., M.D., *Atlanta**

THE IDEA OF CURING a cancer by cutting it out is a simple and appealing one, practiced by ancient man as well as doctors today. During the last two centuries the microscope has permitted the histological study of tissues, which, when correlated with the clinical observations of neoplastic disease in its protean manifestations and ramifications, has led to a concept of the natural history of cancer as a stepwise development or transition from cells growing normally within controlled bounds to cells growing abnormally less and less under control until finally reaching a state of wild and meaningless growth locally and throughout the body.

Treatment of cancer has been based on this concept of its natural history and emphasis has been appropriately placed on the early management of cancers when possible.

Understandably the laity continue to ask: "Did you get it all?" and the majority of the medical profession, surgeons included, for the most part still think in these terms. Many feel that if one or a few cells are left behind failure to cure is assured just as many feel that one or a few bacteria will always cause clinical infection. It is most unlikely that any one cell would be viable and proliferate, but rather a critical mass of cells probably must exist. Some 25 years ago when first we became able to demonstrate consistently malignant cells in the blood stream, it was felt that finding cells in the blood of any patient warranted a grave prognosis. However, it was a pleasant surprise when it was observed that patients with cancer cells found in the blood did not regularly have a poorer prognosis. It appeared clearly that malignant cells must overcome an antagonistic environment.

Hormones, Chemotherapy

Reassessment of our concepts of the factors participating in the natural history of cancer have had to be revised. The influence of several hormones on neoplastic disease has been clearly demonstrated and studied. Epidemiological phenomena related to the incidence of many cancers have been surprising and many or most remain unexplained.

Aside from caustic agents, which have been used for literally thousands of years, nitrogen mustard in the late 1920's was probably the first chemotherapeutic agent found to be effective against certain neoplastic processes particularly lymphomas. Gradually there has been developed during the last 30 years a great number of drugs known to depress various neoplastic activities. Initially lymphomas and leukemias proved to be the disease processes most susceptible to chemotherapy. In the early 1950's Methotrexate was found to produce a high rate of cures of patients

* Professor of Surgery, Emory University School of Medicine; Director, Robert Winship Memorial Clinic, 1365 Clifton Road, N.E., Atlanta, Ga. 30322.

with choriocarcinoma previously almost uniformly fatal. Slowly but inexorably during the last 20 years more chemotherapeutic agents have produced depression and occasionally prolonged control of neoplastic processes.

The occasional observation and documentation of the spontaneous regression of tumors has been intriguing to say the least and has suggested that immune mechanisms exist. Coley's toxin was one of the earlier examples of stimulation of the immunocompetence of an individual. Steadily the basic study of immunology provides increasingly bits of evidence that immune bodies do exist and that their presence can be determined. They can be stimulated, depressed, and overwhelmed. Further, an antibody referred to as "transfer factor" may be used to inhibit the growth of a neoplastic process in some settings. Several agents including drugs and organic substances appear to influence the immunocompetence of response of an individual. This response can be measured by several parameters.

It is apparent that multiple factors are involved in the causation, the stimulation and the depression of neoplastic processes. Probably the more pertinent question we should ask, however, is not what causes cancer but rather what keeps the majority of individuals from developing cancer. This question will lead us to assume and probably correctly that the resistance factors are predominent and quite possibly the reason we cure even early cancers is the presence of significant immunocompetence or resistance on the part of the individual, whether it be an antibody function and/or other elements in a hostile host such as hormones, a particular chemical milieu, or powerful both specific and non-specific antibodies yet to be identified.

Not by Surgery Alone

While surgery still plays and probably will play a major role in the management of cancer, it is somewhat sobering to surgeons as well as radiologist and chemotherapist to contemplate that possibly we may not cure even early cancers by extirpative or destructive or toxic methods alone. If a tumor has not metastasized before removal, it still may have served as an antigen to stimulate immunocompetence to prevent spread or to prevent the development of new similar primaries. When we are dealing with more advanced tumors, either exceptionally large ones or others which may have metastasized, it may be that by surgery we remove the bulk of the malignant cells which have been overwhelming the immune capability of the individual. The remaining disease may possibly then be restrained or destroyed by the immune potential. Cure in most individuals then may be effected by the ability of the host to respond and complement other therapeutic modalities. At the same time we must also remember that surgery, radiotherapy and chemotherapy may unpredictably have an adverse influence on the immune mechanism and we must try to avoid doing more harm than good in our enthusiastic attempts to cure.

Surgery and, to a lesser degree, irradiation are likely to remain the prominent modalities in attempting to cure early cancer. Chemotherapy undoubtedly will play an increasing role in treating advanced cancer and possibly even early cancer. But we must have better indices as to what is actually early cancer. In those instances where these indices show that we are not dealing with early cancer, chemotherapy and immunotherapy must be brought to bear much sooner and with hopefully much greater chance of success. These modalities, whether they be new drugs or immunotherapeutic methods, may be not only ancillary but actually critical to the ultimately successful treatment of cancer. ■

Oral Contraceptives: A Risk Factor for Myocardial Infarction?

DOUGLAS C. MORRIS, M.D., *Atlanta**

In recent years there has appeared in the literature an increasing number of case reports of young females suffering acute myocardial infarctions while using oral contraceptives. The literature now includes at least 29 such reports. All of these women have been less than 45 years of age and all but two are less than 40 years of age. With two exceptions, all of the patients had been taking oral contraceptives for longer than one year. The evidence incriminating oral contraceptives in these instances has been primarily circumstantial in that these myocardial infarctions were occurring in members of a segment of our population at extremely low risk for developing coronary atherosclerotic heart disease.

The most incriminating evidence for an association between myocardial infarction and oral contraceptives has been reported from the United Kingdom. The 1968 report to the Committee on Safety of Drugs in the United Kingdom documented a strong relationship between pulmonary embolism and cerebral thrombosis and the use of oral contraceptives. This same report noted a greater use of oral contraceptives among women who died from coronary thrombosis than the control group. The difference between these two groups, however, was not quite significant and a definite association could not be established at that time. Then in 1969, and again in 1972, investigators at the Royal Infirmary of Edinburgh reported significantly higher use of oral contraceptives in females less than 40 years of age suffering myocardial infarction than in the general population (50 per cent vs. 13 per cent in 1969 and 55 per cent vs. 11 per cent in 1972).[1, 2] These investigators, however, did emphasize that the majority of these patients had an additional risk factor for developing coronary atherosclerosis. In the last six months two epidemiological studies from the United Kingdom have also suggested that oral contraceptives increase the risk of myocardial infarction.

Independent of Other Risk Factors

Mann and Inman investigated a series of women under 50 years of age who died from myocardial infarction.[3] These investigators concluded that the frequency of use of oral contraceptives was not only greater in those women dying of myocardial infarctions but that oral contraceptives exerted an effect independent of other risk factors. The data from this study also suggests that the association with myocardial infarction is most striking in those women using oral contraceptives for greater than two years. The increased risk for developing myocardial infarction appeared to disappear with the cessation of use of oral contraceptives.

The other epidemiological study, likewise, indicates that the risk of myocardial infarction increases with prolonged use and that this risk ends with discontinua-

*Carlyle Fraser Heart Center at Crawford Long Hospital, 25 Prescott St., N.E., Atlanta 30308 and Department of Medicine, Emory University School of Medicine. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

tion of the "pills."[4] This study, like those from the Royal Infirmary of Edinburgh, emphasizes that the risk for developing myocardial infarction is most significant in those women with other coronary atherosclerotic risk factors. Both of these epidemiologic studies indicate that the association between oral contraceptives and myocardial infarction increases with advancing age of the patient.

Investigations of the type which I have referred to provide little evidence as to the mechanism by which oral contraceptives give rise to a risk of myocardial infarction. The fact that the patients with infarction have usually been using oral contraceptives for relatively long periods of time might suggest that their use contributes to atherogenesis. In this regard, several investigators have noted that women taking oral contraceptives have mildly impaired glucose tolerance and slight increases in plasma triglycerides. Another possible mechanism for the predisposition to myocardial infarction is production of a hypercoagulable state. The epidemiologic evidence from the Committee on the Safety of Drugs suggests that women using oral contraceptives are in a hypercoagulable state; i.e. increased risk of venous thromboembolism and pulmonary embolism. In addition, increased platelet adhesiveness and increased levels of Factor VII and Factor X have been recorded in women using oral contraceptives. A third possible mechanism for the association between birth control pills and myocardial infarction is a direct effect on arterial walls. Experimental data in rats and post-mortem findings of endothelial proliferation and subintimal fibrosis in the pulmonary arteries of women dying from pulmonary emboli while on the "pill" supports such a mechanism.

While oral contraceptives remain to be unequivocally established as an independent risk factor for myocardial infarction, the clinical implications of these studies seem clear. First, cigarette smoking, a recognized risk factor for coronary atherosclerosis appears inadvisable in women using oral contraceptives. More importantly, serious consideration of other methods of contraception should be given in those women manifesting one of the other risk factors for developing coronary atherosclerosis. These risk factors include diabetes mellitis, hyperlipidemia, hypertension, and a family history of premature development of coronary atherosclerotic heart disease. Prolonged uninterrupted use of oral contraceptives would seem especially inadvisable in these women. ■

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DR. NADLER SPEAKS AT GEORGIA BAPTIST HOSPITAL

Physicians are invited to the Joseph Yampolsky Honorary Lecture, entitled "Newer Developments in the Detection and Treatment of Genetic Disorder" which will be presented at 8 p.m., Tuesday, November 11, 1975 in the Auditorium of Georgia Baptist Hospital in Atlanta. The speaker will be Henry L. Nadler, M.D., chief of staff of Children's Memorial Hospital, Given Research Professor, and chairman of the Department of Pediatrics at Northwestern University in Chicago.

New Developments Concerning the "Captain of the Ship"

ROBERT L. HINKLE, *Atlanta**

APPELLATE COURT DECISIONS over the past few years have caused much discussion of the respective liabilities of hospitals and physicians for allegedly negligent medical care within the hospital. One hears frequently the statement that hospitals have evolved from institutions which did no more than furnish facilities in which physicians practice medicine into complex medical centers which assume a great deal of independent responsibility for treating patients. This perceived change in the nature of hospitals has been accompanied by expansion of the hospital's legal liability. No longer can a complaining patient seek redress only against the physician, who as "Captain of the Ship" was traditionally said to assume sole legal responsibility for the treatment of the patient. Now there is a medical care fleet rather than just one ship, and the hospital itself is in command of at least part of the fleet.

An attempt to sort out the possible liabilities of hospitals and physicians should begin with a review of some basic principles of tort law. First, anyone who performs a negligent act is liable to whomever the act injures. The standard of care imposed on all of us is legally defined as what a "reasonably prudent person" would do under the circumstances, a standard which obviously leaves much room for jury discretion. In the typical situation where a physician performs an operation in a hospital with the assistance of a nurse, the patient can seek recovery from whoever is negligent among the hospital, the physician, and the nurse. For example, if the nurse fails to act prudently in performing a sponge count, he or she will be liable. If the physician fails to act prudently in obtaining the results of the sponge count, he or she will be liable. And if the hospital fails to act prudently in requiring that a sponge count be made, it will be liable.

That much is fairly straightforward. However, the situation is more complicated, because a second general principal of tort law is that an employer is liable under the doctrine of *respondeat superior* for the negligent acts of his employees. Thus, if a nurse is an employee of a physician, then the physician can be held liable on the basis of the nurse's negligence. If the nurse is an employee of the hospital, then the hospital can be held for the nurse's negligence. And if the physician is an employee of the hospital, then the hospital can be held for the physician's negligence.

Determining Liability—Two Problems

Therefore, there are two basic problems in ascertaining the respective liabilities of the various parties: the determination of who has been negligent, and the deter-

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mination of who is an employee of whom. As to both questions, the trend has been toward increasing liability of hospitals.

The subjection of hospitals to liability for their own negligence appears to have increased sharply after the Illinois Supreme Court's 1964 decision in *Darling v. Charleston Community Memorial Hospital.*[1] A broken leg patient became an amputee because of improper application of the cast and improper supervision of his recovery. The hospital was held independently negligent in failing to provide a sufficient number of trained bedside nurses to supervise the patient's recovery and in failing to adhere to its own regulation requiring consultation with or examination by members of its staff skilled in the particular treatment. In and of itself the Darling case was not a great departure from the "Captain of the Ship" rule, because the hospital was found to have violated one of its own rules. Yet it seems to have spawned quite a progeny. More recently, hospitals have been held negligent in allowing physicians who they should have known were incompetent to remain on their staffs.[2] In order to reduce a hospital's liability for its own negligence, the hospital administrator will keep close track of hospital activities.

Hospital liability under the doctrine of *respondeat superior* is also increasing. The most frequently litigated situation involves emergency room treatment. Two typical recent cases (one a decision by the Georgia Court of Appeals)[3] have held that hospitals could be liable for negligence of physicians who were paid directly by the hospital to treat emergency room patients.[4] A recent Delaware case goes further. In *Schagrin v. Wilmington Medical Center, Inc.*[5] the hospital had contracted with "Doctors for Emergency Services," a professional partnership, in an apparent effort to relieve itself of responsibility for operating its emergency room. A nine-year-old girl fell on a sidewalk and cut her leg on a soda bottle, and was taken to the hospital's emergency room. Eleven days later she died from infection. The court allowed her family to maintain an action against the hospital, saying that notwithstanding the contractual arrangement with Doctors for Emergency Services, there was a jury question as to whether the physician who treated the girl was an "employee" of the hospital. These cases indicate that a hospital desiring to maintain an emergency room may well be unable to escape liability, even where the hospital itself is not negligent in any respect.

Contrasting Approaches to Negligent Nurse

Another common situation involves a negligent nurse. Where the nurse is assisting a physician, the "Captain of the Ship" approach would hold the physician rather than the hospital liable on the theory that it is the physician who is in position to control the nurse. Two recent cases show the contrasting approaches now taken to this problem. In *Tonsic v. Wagner*[6] the Pennsylvania Supreme Court said that both the physician and the hospital could be held liable on account of a nurse's negligence in leaving a "Kelly clamp" in the patient's abdomen during an operation. The court rejected the argument of a dissenting judge that only the physician could control operating room activity so that the hospital should not be liable. In *Foster v. Englewood Hospital Association*[7] an Illinois court moved even further from the "Captain of the Ship" approach. A patient died from lack of oxygen due to the negligence of a nurse-anesthetist during a shoulder separation operation. The court said that only one party could be liable under *respondeat superior*—in this case the hospital and not the physician. Although the physician could control the manner of the nurse's work, the nurse was subject to hospital rules and it was the hospital which paid her and which could fire her. These cases indicate that the liabilities of the respective parties will vary from jurisdiction to jurisdiction. The only thing which can safely be said is that neither physicians nor hospitals can assume that they are immune from liability for nurses' negligence.

It is clear, then, that the modern hospital may not be shielded from liability for

medical accidents under the old "Captain of the Ship" rule. The hospital may be liable for its own negligence, and these recent cases indicate that courts are likely to find it negligent in an increasing array of circumstances. The hospital may be liable for negligence of physicians who are "employees," and decisions such as the *Newton County Hospital* case may indicate an increasing willingness to hold physicians to be "employees." Finally, the hospital may be liable for a nurse's negligence, and cases such as *Tonsic* and *Foster* indicate that this may be true even where the nurse is assisting an operating physician who might once have been labled the "Captain of the Ship." ■

REFERENCES

1. 33 Ill 2d 326, 211 NE 2d 253 (1965).
2. Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P2d 335 (1972); Mitchell County Hosp. Authority v. Joiner, 229 Ga. 140, 189 SE 2d 412 (1972).
3. See article in August, 1974 *JMAG*.
4. Wells v. Woman's Hosp. Foundation, 286 So. 2d 439 (La. App. 1973); Newton County Hosp. v. Nickolson, 132 Ga. App. 164, 207 SE2d 659 (1974).
5. 304 A. 2d 61 (Del. Super. 1973).
6. 329 A. 2d 497 (Pa. 1974).
7. 19 Ill. App. 3d 1055, 313 NE2d 255 (1974).

SPINAL CENTER EMPHASIZES REFERRAL AND TEAM APPROACH

The Shepherd Spinal Center opened in August at West Paces Ferry Hospital as a categorical unit for the treatment of patients who have sustained an injury to the spinal cord causing paraplegia or quadriplegia. The unit is located in a 14-bed section of the 300-bed acute hospital on the first floor of the "B" Building and has the capability of being expanded to 24 beds.

David Apple, Jr., M.D., is the medical director of the new unit. Dr. Apple is moving his office to the West Paces Ferry Hospital location and will divide his time between the spinal unit and an orthopedic practice emphasizing upper extremity reconstruction. He has had a strong interest in the problems of rehabilitation since post-graduate training at Rancho Los Amigos Hospital in Los Angeles, Calif., and has been associated with the Easter Seal Rehabilitation Center since coming to Atlanta in 1970.

The Shepherd Spinal Center is modeled after other spinal centers in the United States and is one of the first in the Southeast. The Center embraces the modern concepts of rehabilitation, one of the cardinal precepts being early referral. If a patient with a spinal injury can be transferred to such a specialized center as soon after onset as possible (within 24 to 48 hours), morbidity can be shortened. If rehabilitation can be started soon after the injury occurs, the patient often can be fully rehabilitated in 70 to 100 days rather than the six to 12 months it took in past years. This can be accomplished by telescoping the five stages of rehabilitation rather than using the more classical one stage at a time approach.

After almost a year of planning and research, James Shepherd, president of the Board of Directors of the Shepherd Center, and himself a spinal patient, outlined the ingredients for a successful operation of a center. He stated there are four important requisites. One is an area for the treatment of this specific problem rather than a general rehabilitation unit. A second point is locating the unit adjacent to or as a part of an acute hospital. A third point is a geographical full director who has total authority and responsibility for the unit.

Mr. Shepherd said the final point is a well-trained staff of sufficient numbers to provide the intensive care required to produce an outstanding job. To meet this requirement, the Center recruited a nurse and a physical therapist and had them undergo a month's training at the Craig Hospital, a leading spinal center in Denver, Colorado. Joining the staff are an occupational therapist and a physical therapist from Craig Hospital, each with four years of experience in the field.

In conjunction with the inpatient unit, an outpatient clinic has been opened to provide follow-up and updating of new and old spinal patients. The outpatients can come to the Center and receive a full evaluation yearly. This will include therapy as well as routine medical care including urological and chest check-ups.

The Center provides a full patient care team approach and experienced personnel to aid in transportation of patients to the Center. After arrival, each patient receives a complete medical exam as well as evaluation by a physical therapist, occupational therapist, social worker and psychologist or psychiatrist if needed. Acute organ problems and complications are treated by a competent staff of consultants available in the various specialty categories. As the patient progresses, social and counseling are provided. Prior to discharge, the home environment is surveyed and altered to make patient care and mobility as easy as possible.

The goal of the Center is to return the patient to the maximal level of independence consistent with the level of injury in the shortest period of time possible. This can be accomplished by early referral before physical complications and emotional scarring have had the opportunity to develop.

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main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

I've told this before . . . .

(Ed. note: This Gulla lingo tale from Georgia's coastal areas by J. G. McDaniel, M.D., describes a crisis situation in which one mistake meant trouble, but two mistakes became a blessing. Contributions for this feature page are solicited and should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Rattlesnake in the Kitchen

IN THE LATE 30's, several of us fished off and on in the coastal waters around St. Simons Island, especially when the speckled trout were biting.

When possible we used a guide by the name of Cuisie. I never did know what Cuisie's last name was, nor did it make much difference, we had his telephone number and knew where he lived. In those days if you lost his number and wanted to call him "long distance," any telephone operator in Brunswick or St. Simons knew who Cuisie the fishing guide was and would cheerfully ring his phone.

This particular spring morning, two of us were fishing with Cuisie. Along about 9 o'clock a black cloud appeared and we came back to the boat dock as did several other boats. At this dock was a little store run by a man named "Coot." Coot kept an eye on the boats, sold soft drinks, tobacco, had a small supply of canned meats and crackers. We gathered under a little shed in front of the store to wait out the shower. After the rain slacked a little, several of the guides went up to Coot's house. I do not know what they went up there for, but they were in a jovial mood when they returned and were quite talkative.

They were sitting on the floor at one end of the shed and we on the other end. They kept talking and laughing and I did my best to tune my ear in on their "Gulla" lingo, which is so difficult at first to understand. I heard one of the guides say to Cuisie, "Cuisie, what's dem two holes doing in Coots kitchen floor?" . . . Cuisie laughed heartily and said, "I'll tell you about dem holes."

"Right after Christmas we had a right long cold snap here on the island, some ice in places, den it let up and got warm as it is today. Long about 10 or 11 o'clock Coot went up to his house for something and when he got there, he seed this big rattlesnake sunning hisself on the top steps that went into the kitchen. De top step was level wid the kitchen floor and de door was open. Coot looked for de hoe and couldn't find it. Den he spotted an old tree limb dot was 'bout as big as the calf of yo leg and 'bout 6 foot long. Coot tiptoed right close to de old snake . . . course Coot he's a scared and kept looking around on the ground to see if there's another one around. Coot drew dat big stick back and heaved a mighty blow—too strong, though, 'cause de old limb broke half in two and de end dat was supposed to hit de snake fell on de step jest below him.

"Course, dat woke up de snake. Den he's scare't and he crawls in de kitchen as fast as he can and goes behind a little pile of stove wood, coils up and starts rattling. Now de other door dat comes into the kitchen, it's closed . . . and Coot starts hollering to Ellen to bring him his shotgun and to come out de front door and bring it round de house. Course, wife like, she wants to know what he want de gun for and Coot hollers back 'deys a rattlesnake in de kitchen!' Den Ellen hollers, 'Oh, my God, Oh, my God!' But she bring him dis old single barreled shotgun. But she had to go back for the shells. She finally found all three of them in an old cigar box—dey was old and dingy.

"Coot loaded up, cocks his gun and waits there in the kitchen door. After a little, de old snake, he sticks his head out from around the wood and Coot takes dead aim. He pulls de trigger and all he hears is 'ping.' He cocks it again and again

and all he hears is 'ping.' Then he puts in another shell, and by this time de ole snake is crawling along the edge of the wall a-sticking his forked tongue in and out.

De ole gun snaps again, but de next time she went off 'ker-bloom!' but dis time Coot, he's nervous and he missed him about a foot. All he done was make a hole in de kitchen floor. De snake he went back behind de wood and dis time he's really rattling up a storm. Coot puts his last shell in de gun. He called to Ellen—he wanted her to go borrow another gun and some shells, but she was long gone from that house. De old snake quit rattling after a few minutes and musta done some thinking and figured that de only way he could git out was like he come in—and dat was through de door. Se he started crawling toward Coot and that made Coot sho-nuff nervous. This time de gun went off de first time, but all the shot done was to put another hole in de floor about a foot in front of the snake and de old snake went through that hole and dropped down under the house. And course, that's when Coot took off up the road.

"Coot says he aint gonna never patch up dem holes, cause if another snake ever gits in his kitchen, he wants him to have another way to get out excusing the kitchen door!"

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FOUNDATION TO ASSIST COMMUNITY HOSPITAL-SPONSORED PRIMARY CARE GROUP PRACTICES

A $45 million investment program to assist selected community hospitals across the nation to construct facilities for new group practices providing general medical care for families was announced today by the nation's life and health insurance companies.

Sixty hospitals receiving grants from The Robert Wood Johnson Foundation of Princeton, N. J., to establish community hospital-sponsored primary care group practices will be eligible to apply for the financing, which will be made available on a competitive basis as long-term loans.

The Foundation—the largest in the nation specializing in health problems—has committed $30 million to the program which, when coupled with the insurance industry's funds, creates the largest private initiative in more than a decade to improve access to health care. No federal or state funds are involved in the overall program.

The objective of the program is to encourage community hospitals to sponsor the development of group practices specifically organized to attract physicians to provide first-line around-the-clock primary care to patients and their families on a continuing basis, according to Dr. David E. Rogers, president of the Foundation.

An important effect of the program will be to ease the burden on community hospitals which are having increasing difficulty in meeting the service demands placed on their emergency rooms and outpatient departments as substitutes for the doctor's office, he noted.

Each group practice will consist of at least three full-time physicians (family practitioners, general internists, pediatricians or obstetricians, typically) organized to provide primary care seven days a week.

It is expected that most of the practices will need a full-time administrator skilled in group practice management and will employ other trained medical personnel such as nurses and physician's assistants. Each practice ultimately will be expected to provide service for more than 15,000 patients, thus involving approximately one million Americans in the program.

Each hospital will be free within general limits to establish its group practice in whatever way seems best. Some may wish to set up the facilities within the hospital itself, while others may decide to operate from new or renovated facilities adjacent to or near the hospital, or even some distance away.

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SOCIETIES

Members of the **Bibb County Medical Society** socialized at the group's annual picnic August 7 at Fickling Farms in Macon. Invited as special guests were members of the Georgia House and Senate and members of the MAG Legislative Committee.

The **Medical Association of Atlanta** will have no September regular meeting, but in October will present a panel discussion on liability insurance, headed by William W. Moore, Jr., chairman of MAG's Committee on Professional Liability Insurance. Nominations for officers also will be taken at the October Meeting.

The Northern District of MAA was to meet September 16 with Congressman Elliott Levitas, who represents the 4th District of Georgia in the U. S. House of Representatives.

PERSONALS

First District

Three members of the Georgia Medical Society shared their thoughts on "Growing Old Gracefully" with members of the Savannah Rotary Club. Recommending moderation in everyday living were **Samuel F. Rosen,** 70, **Julian K. Quattlebaum, Sr.,** 79 and **James C Metts, Sr,** 78. Dr. Rosen commented that "Medicine is a jealous mistress, yet all should have diversion. Most important spare some time for your family."

Frank Glenn has opened a practice in urology in

Statesboro, after serving his internship and residency and three years of private practice in Savannah.

Third District

V. C. Wade, formerly of Valdosta, has moved his practice in general medicine to Americus. Dr. Wade was graduated from the Medical College of Georgia, served in the U. S. Navy on two occasions and interned at the U. S. Naval Hospital at Portsmouth, Va. He had been in Valdosta 20 years.

Fifth District

John M. Anderson has been elevated to Life Fellow from Fellow of the American Psychiatric Association during ceremonies at a recent meeting in Anaheim, Calif.

James H. Larose will represent Georgia in the House of Delegates of the American College of Nuclear Physicians.

Cecil V. Johnson is the new chief of staff of Peachford Hospital in Atlanta.

Sixth District

David Frolich and **Stephen Rando** of Macon have become board certified radiologists.

J. S. Holder, LaGrange has been appointed to an advisory panel for the American Group Practice Association. He will help provide information and assistance to the National Health Service Corps in developing cooperative relationships between NHSC sites and group practices in critical health manpower shortage areas.

James E. Smith has now associated with Robert W. Oliver, Jr., in the practice of general and vascular surgery in Dublin. Dr. Smith is certified by the American Board of Surgery, was graduated from the Medical College of Georgia and has just completed two years as chief of surgery at the Naval Hospital in Port Hueneme, Calif.

LaGrange physician **J. Render Turner** has been elected president of the Medical College of Georgia Foundation, Inc. Others serving with him are Robert D. Waller, Albany, as first vice-president; Floyd C. Jarrell, Jr., Columbus, second vice-president; and Robert G. Ellison of Augusta as secretary-treasurer.

Tenth District

William B. Strong of Augusta was one of four U. S. physicians selected as faculty of the 38th annual American College of Cardiology Circuit Course sent to Israel, Romania and Bulgaria recently.

Elaine B. Feldman, Augusta, has received a grant from the Georgia Heart Association for the project, "Cholesterol Absorption in Fatty Acids."

Sam A. Threefoot, Augusta, served as chairman of the Council on Circulation and served on the board of directors at a meeting of the American Heart Association in Dallas recently.

DEATHS

Clarence Landers Ayers

Former president of the Medical Association of Georgia and state senator, Clarence Landers Ayers, 98, died August 5 in Toccoa.

The family physician had practiced medicine 72 years, the first four in Carnesville after graduation from Emory University School of Medicine, and the remaining in Toccoa. A horse and buggy provided transportation the first eight years, after which he moved up to a Model T Ford. Some 5,000 babies were delivered by him.

Dr. Ayers was active in the Medical Association of Georgia, serving as president from 1934 to 1935, as councilor and vice councilor, as president of the Ninth District and secretary of his county society. Also giving to the community, he was active as a Mason, Shriner, member of the Toccoa School Board and Kiwanis Club past president. In 1949 he was voted "Man of the Year" by the Toccoa Chamber of Commerce. When 77 years old, Dr. Ayers succsessfully ran for a position as state senator and served two terms.

He is survived by his daughters, Mrs. Mary Helen Ayers McGee and Mrs. Margaret Ayers Brown of Toccoa; sons, Howard (Doc) Ayers of Athens and Bill Ayers of Toccoa; sister, Miss Undine Ayers of Carnesville; and brother, Sanford Ayers of Carnesville.

Reuben D. Cooper

Atlanta diagnostic radiologist Reuben D. Cooper, 41, died August 11 in a boating accident on the Nantahala River near Asheville, N. C.

Dr. Cooper was graduated from Vanderbilt University and Emory University School of Medicine, for which he was an assistant clinical professor of radiology. He was on the staff of St. Joseph's Infirmary and was a consultant for the Medical College of Georgia.

Dr. Cooper was a member of the Atlanta Clinical Society, Radiology Association of Georgia, Atlanta Radiological Association and the American Society of Neuroradiology. He had served in the U. S. Army and was a member of Sigma Alpha Epsilon fraternity, Phi Chi and Alpha Omega Alpha medical societies.

Survivors include his widow, Mrs. Diane Henry Cooper; four sons, Reuben Dale Cooper, III, Clay Lamont Cooper, Todd Dibrell Cooper and Pace Carris Cooper; parents, Mr. and Mrs. R. D. Cooper of Cincinnati, Ohio.

John I. Hall

John I. Hall of Macon, who retired in 1973 after practicing medicine 40 years as an orthopedic surgeon, died July 13 at the age of 70.

Dr. Hall was born in Macon and attended Mercer University and the Medical College of Georgia from which he was graduated in 1928. His internship was served at a New York hospital for crippled children, after which he served in the U. S. Naval Reserve Medical Corps during World War II, retiring with the rank of commander.

Formerly chief of staff at the Medical Center of Central Georgia, Dr. Hall served as a teacher-consultant there after his retirement from active practice. He was a member of the American Academy of Orthopedic Surgery, the American Academy of Orthopedic Surgeons, The Southern Medical Association, the Georgia Orthopedic Society and was a president of the Bibb County Medical Society in 1940. He was a member of the First Presbyterian Church of Macon, Palaver Club, Alpha Omega Alpha honorary medical society and the Kappa Alpha order.

He is survived by his widow, Mrs. Jessie Hollomon Hall of Macon; son, John I. Hall, III, of Macon; two daughters, March Hall and Bruce Lynde Hall of Macon; three sisters and two brothers.

Walter Oliver Pendley

Rome physician Walter Oliver Pendley, 58, died July 13 in a Rome hospital. He had practiced medicine in Floyd County 25 years.

Dr. Pendley was born in Bartow County February 2, 1916, attended Berry College and was graduated from Emory University School of Medicine. He was a veteran of World War II, and served his internship at Bethesda Hospital in Maryland. A residency in surgery was served at Kennedy Veterans Hospital in Memphis, Tenn.

He is survived by his widow, the former Evelyn Hoge; daughter, Mrs. Richard Ellis of Virginia Beach, Va.; son, Lee Pendley of Rome; two sisters, two brothers; five grandchildren.

EMORY PROJECT STUDIES PSYCOPHYSIOLOGICAL EFFECTS OF PAIN-KILLING DRUGS AND TECHNIQUES

They're trying to get a handle on dental pain at the Emory University School of Dentistry. Using paid volunteers in a research project supported by the National Institute of Dental Research (NIDR), Emory dental scientists will study both physiological and psychological aspects of pain. They will also compare effectiveness of various pain-killing drugs and techniques including lidocaine (Xylocaine), nitrous oxide-oxygen analgesia, and acupuncture analgesia.

The project has received a grant of $40,000 for the current year from NIDR, an agency of the U.S. Department of Health, Education, and Welfare. Dr. Lindsay M. Hunt, associate professor and chairman of the Department of Oral Biology, Emory School of Dentistry, is principal investigator with Dr. Yung-Fong Sung, Department of Anesthesiology, and Dr. K. V. Anderson, Department of Anatomy acting as co-investigators.

"Pain is a very difficult sensation to define," Dr. Hunt said. "What is one man's pain is another's pleasure. The literature provides ample evidence that dental pain thresholds vary widely according to such factors as age, sex, time of day, etc.

"Unlike most previous studies, ours will attempt to define the dental pain experience in terms of the emotional and psychological state of the subject as well as by purely physiological factors."

Using various types of dental anesthesia, Dr. Hunt and his colleagues will electrically stimulate teeth and ask the volunteers to indicate by finger signals the type and degree of sensation they are experiencing. The project will last three years and about 65 volunteers, primarily from the Emory student body, will be used.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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The Month in Washington

The American Medical Association has filed a lawsuit to block the implementation of new federal drug regulations that would pressure physicians to prescribe low-cost drugs for Medicare and Medicaid patients.

The Maximum Allowable Cost (MAC) regulations were approved in final form by Health, Education and Welfare Secretary Caspar Weinberger a few days before he left office.

Within 24 hours AMA filed suit in Northern Illinois District Court contending the program is the epitome in regulatory control—"an impossible labyrinth of drug regulations without assuring a favorable cost-benefit ratio."

The AMA contends the constitutional rights of both patients and physicians would be violated and that the program would produce adversary relationships among patients, physicians and pharmacists.

The disputed regulations would require pharmacists filling prescriptions for Medicare-Medicaid patients, primarily Medicaid, to be reimbursed on the basis of the lowest cost at which the product is generally available to providers. A higher-priced drug reimbursement would be allowed only if the physician signs that it is "medically necessary." The purpose is to stimulate purchase of generic drugs and discourage purchase of brand names that carry higher costs.

By and large physicians will be affected as they deal with Medicaid patients since there is no substantial outpatient benefit for Medicare. In states with anti-substitution laws, a Medicaid prescription for a brand name more expensive than the MAC would mean the patient would have to make up the difference in price unless the physician would be willing to change the prescription to another brand or generic prescription or sign that it is medically necessary.

At an HEW news conference, officials predicted most physicians would go along with the program, estimating that one-half of one per cent would use the "medically necessary" route for brand names that exceed the MAC.

Government Interference

The AMA suit, however, argues that the regulations "violate every one of the drug reimbursement requirements of the Medicare-Medicaid statutes" and defy the law inasmuch as they represent government interference with medical practice by telling physicians which drugs they should prescribe.

Weinberger estimated the MAC program would save federal and state governments $60 million to $75 million a year when it swings into full operation within three to four years.

In addition to the control program, HEW will send all physicians a list of most frequently prescribed drugs along with the prices community pharmacies pay for them. The aim is to encourage physicians to prescribe cheaper products in their regular, private practice.

No sanctions are provided for physicians who decide to write out the "medically necessary" prescription message, but HEW officials speculated that state health agencies might take a look at physicians who do this consistently for all their Medicaid patients. The possible penalty by the state, if it wishes, would be ouster from Medicaid participation, according to the HEW officials.

Before a Maximum Allowable Cost can be established for drugs, the Food and Drug Administration must first indicate that there are no bioequivalence problems among its several brands. The HEW Pharmaceutical Reimbursement Board would then propose a MAC at a level equal to the lowest cost at which the drug is generally available to providers. Before the MAC can officially be established it must be reviewed by a non-governmental advisory committee and published in the Federal Register for comment.

The regulations establish both the Pharmaceutical Reimbursement Board and the five-member outside advisory group.

HEW said about one quarter of commonly prescribed drugs are available from multiple sources. However, the number for which bioequivalence problems can be ruled out is smaller.

The reimbursement that a pharmacist receives for drugs he provides Medicare and Medicaid patients will be based on an estimate of his cost of buying the drug plus a dispensing fee, or on his usual charge to the general public, whichever is the smaller. Program agencies such as a state Medicaid program would make the estimates according to price information supplied on a regular basis by HEW.

The original MAC proposed regulations were amended in some respects. At first, it was recommended that exceptions would be made only if physicians certified the drug was the only one effective or that could be tolerated by the particular patient.

An FDA official said this section was changed in an attempt to meet AMA objections.

The MAC program isn't slated to begin for eight months and will cover at the start some 15 to 20 drug classifications.

Some 2,600 comments were filed with HEW on the MAC proposal with less than 300 favorable.

Health Manpower Bill

A health manpower bill costing $1.7 billion to aid medical and other health schools has been approved by the House of Representatives.

The measure was stripped on the House floor of a provision that would have regulated residency assignments and ration them by speciality. However, a controversial "payback" provision for medical students did survive the floor fight, though it was watered down.

The American Medical Association waged an all-out drive against both the residency control and payback provisions in the first big medical-legislative battle of the Congressional session.

Though the payback plan was retained in the bill, it was changed on the floor to include a "grandfather" clause exempting all current students, and to allow them a total of three years (instead of 11 months) to

begin their payback, either in cash or in shortage area services, and allowing forgiveness for military service.

The hotly-disputed payback would amount to some $2,000 a year, that portion of the individual students' yearly medical education subsidized by the federal government. It marks the first time that general subsidies to schools would be required to be repaid by students at the schools, and is expected to raise legal questions on constitutionality if it becomes law.

As a result of the amendments on the House floor, no one would be faced with the payback requirement until 1985 or 1986 provided the plan is enacted into law and survives possible court challenge.

Some fancy parliamentary maneuvering blunted the antipayback forces drive. Manager of the bill, House Health Subcommittee Chairman Paul Rogers (D.—Fla.) steered through the palliative "payback" amendments before calling for a vote. The vote to support the provision was 209-153. Under House rules a vote could not then be taken to reject the amended provision.

Leading the battle against the payback plan was Rep. David Satterfield (D.—Va.) who charged it "will certainly violate the spirit, if not the letter, of our constitution."

Terming the plan "a finely baited snare," Satterfield said the medical graduate has to make the decision on cash repayment or service "at a time when he is faced with repaying loans made to provide for his education, the cost of setting up an office, paying for malpractice insurance, and perhaps supporting a family.

"The saddest aspect of all is that the ones who will have no choice but to enter into a period of service will be those medical graduates who come from the poorest families or those with moderate incomes, because under the circumstances they will not be able to do otherwise."

The service payback would be on a year-for-year basis, and for those choosing this option, four years of service would be required in most cases. Otherwise, they would have to pay Uncle Sam $2,000 a year or $8,000 in a lump sum.

VA Salary Lid Raised

The House voted to lift the $36,000 a year salary lid for Veterans Administration physicians and dentists.

The measure, approved on a 382-3 vote and sent to the Senate, would provide $5,000 a year in special pay and $8,500 a year in incentive pay for physicians and dentists working full time for the VA between September 28, 1975 and September 25, 1976. Part-time physicians would be limited to $41,000 and part-time dentists to $36,000.

Medical professionals in the armed forces and the Public Health Service previously had been voted bonus pay.

The American Medical Association had urged Congress to approve the higher pay for VA physicians. Still to be resolved is the $36,000 pay ceiling for other federal physicians under regular civil service.

NHI Overview

The House Ways and Means Subcommittee on Health has opened the first Congressional sessions of the year on National Health Insurance.

Subcommittee Chairman Dan Rostenkowski (D.—Ill.) said the purpose was to provide Congress with an overview of the problems involved in NHI and the thinking of experts in the field who are not formally aligned with any outside group seeking passage of specific legislation.

Rostenkowski also announced full-scale formal hearings on NHI will start in early fall at which specific time legislation will be considered.

Four all-day sessions have been conducted to date, with a fifth session scheduled for September.

Here in capsulated form is a sampler of the views expressed before the subcommittee by some of a host of witnesses:

Dr. E. L. Wynder, president of the American Health Foundation, devoted most of his testimony to urging emphasis in any national program on preventive medicine.

Dr. John Freymann, president of the National Fund for Medical Education, called the present health care system a "monstrosity." At the same time he criticized national health in other countries for stifling innovation. Dr. Freymann urged caution in erecting a national health plan here. "We must build on what we have," he said.

Rashi Fein, economics professor at Harvard University, took the approach that NHI is "a hallmark of a civilized" society in which medical care costs are shared so that the poor have equal access. He opposed catastrophic, and without directly saying so appeared to be supporting the labor NHI bill.

Uwe Reinhardt, economics professor at Princeton University, noted that West Germany's highly nationalized health care system has a worse infant and maternal mortality rate than the U.S. He said there are many very good points about the American system and warned that there are no legislative panaceas. Not only might legislative proposals not result in improvement of health, "but they may cause developments we do not like."

Herman Somers, Princeton professor, suggested that the government become more deeply involved in financing of health care costs, not in its administration. Discontent with the U.S. health system is not due to poor conditions but to greater public expectations. Health care is better now than ever. Present problems are due as much to the government as to the private sector's own faults.

Robert England, M.D., a private practitioner of Carlinville, Ill., was one of the few non-academic physicians to appear before the subcommittee. He said the Indians of this country are the beneficiaries of complete Federal health care and have the worst health of any group in the nation. Labor's aim, Dr. England said, is to shift health costs to the general public so it can negotiate better wage and other agreements from management. Corporations think the same way, he charged.

John Thompson, president of Blue Shield of Massachusetts, thought Congress should view the NHI debate "not in the perspective of the government's desire to continually expand in numbers and services but rather as to which entity can provide services to the public on the most cost effective basis."

Wilbur Cohen, former HEW Secretary and now the dean of the University of Michigan School of Education, said he didn't favor enacting any of the NHI

bills before the subcommittee. He said developing a NHI bill should be a long and continuing process with time to consult fully providers and consumers. Only the executive branch can do this, he said, charging the present Administration is "tragically incompetent." This isn't the year for Ways and Means to act on NHI, he said. The public must be fully educated about a NHI. Benefits should be phased in slowly with a definite schedule, and the program should be administered outside of HEW by a board of three to five people. The longer Congress deliberates on NHI, the better. Swift action would be "a tragic mistake" for "so monumental an undertaking."

Martin Feldstein, economics professor at Harvard, criticized the incentive health insurance provides for hospitals to produce more and better services yet without providing consumers the protection they need against catastrophic costs.

Herbert Klarman, economics professor at New York University, said there's no health care crisis. Some problems today simply reflect past successes. The present system is largely effective. NHI should be a financing instrument only.

Avedis Donabedian, M.D., professor of medical care organization at the University of Michigan, discussed the problems of defining quality care. Too much emphasis should not be given to statistics or to technological procedures at the expense of personal relationships involving physicians and patients. The PSRO program faces two dangers—it might be implemented halfheartedly and it might use the wrong standards. If both results occur, as he predicted they would, neither much harm nor much good would result, but a large bureaucracy would be created.

Rep. Charles Vanik (D.—Ohio), apparently irritated at the defense of the private sector, said most of the doctors he knows think Attila the Hun is a terrible liberal. There are severe problems in health care in this country, Vanik said, such as finding physicians, waiting in hospitals. Congress doesn't "sit here and dream up plans in the night to extend the gargantuan of the federal government. We are pushed and shoved into this by angry constituents." ■

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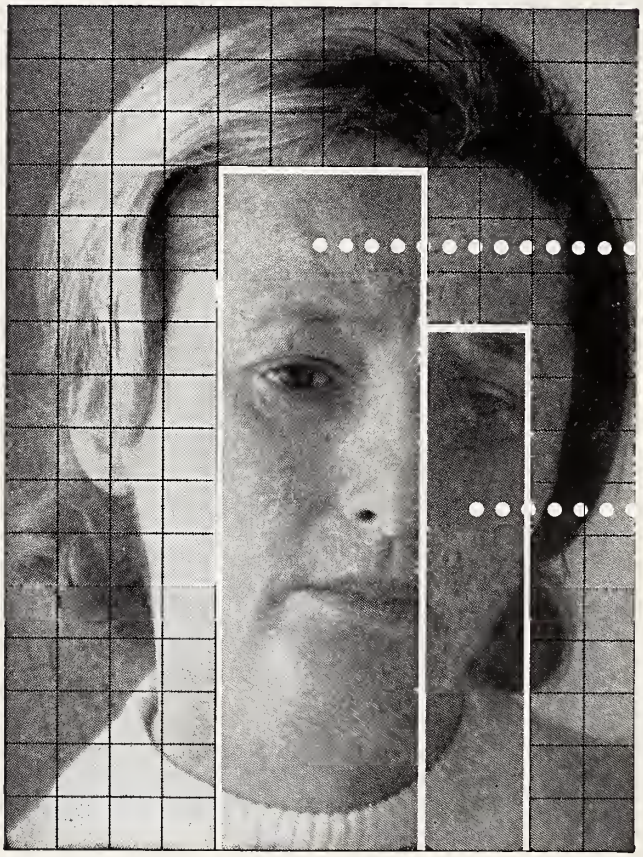
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of the medical association of georgia

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Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1975, Medical Association of Georgia.

Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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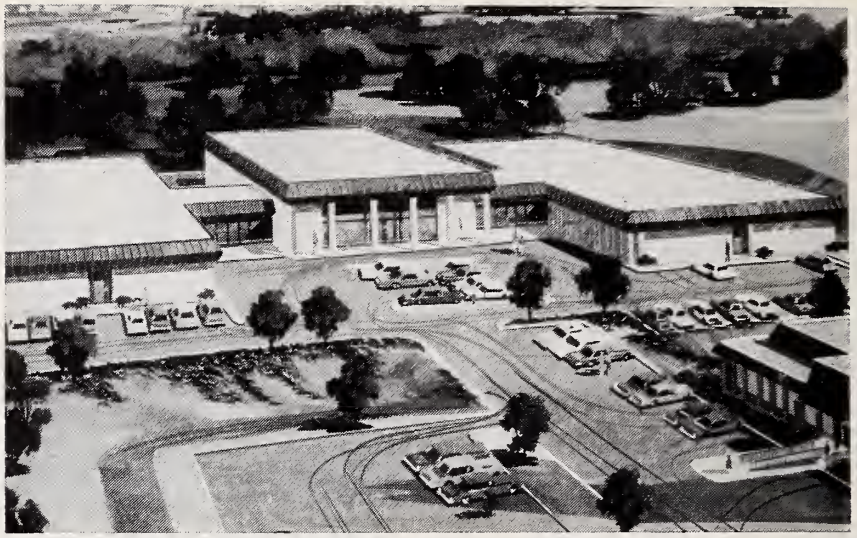
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THE COVER

Graduation from medical school is just the first step in the continuing education of today's physician. Cover design by Atlanta artist Bob Hamill.

THE TREATMENT CENTER at South Cobb Medic Center

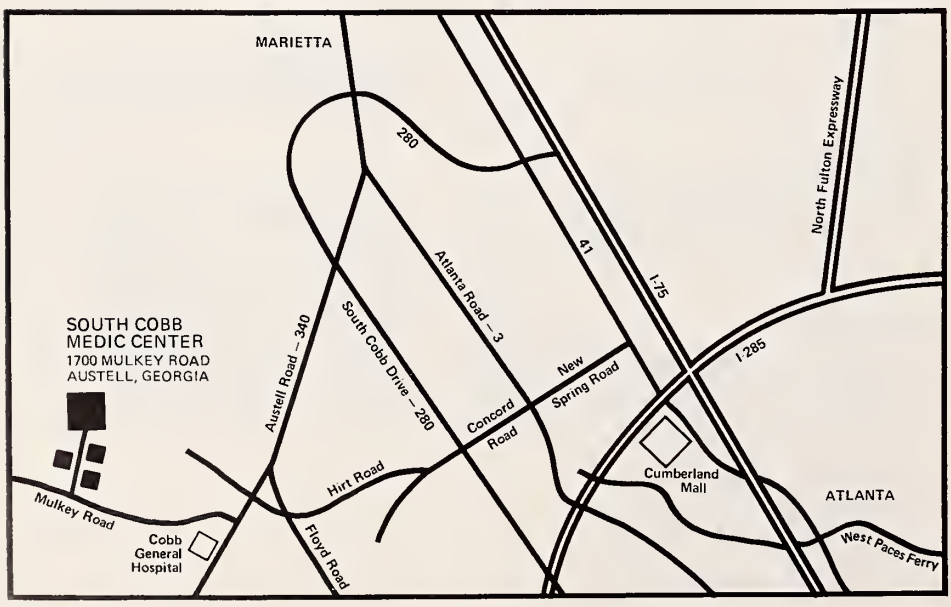


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MAG Annual Scientific Assembly

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THE PURPOSE OF the Medical Association of Georgia's Annual Scientific Assembly is to provide quality continuing medical education to physicians and other health professionals in the Georgia area. Although there is one general session and several activities for physicians' spouses, the assembly is principally a forum for the scientific meetings of the various medical specialty groups. The MAG provides facilities and speaker's funds for each of these programs. Attendees are invited to participate in the meetings of their own specialty groups but are free to attend the meetings of other groups.

Credit

All sessions are acceptable for Category 2 credit for the Physician's Recognition Award of the American Medical Association.

Sessions sponsored by the American College of Chest Physicians, the Georgia Radiological Society and the American College of Physicians are acceptable for Category 1 credit toward the Physician's Recognition Award.

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REGISTRATION for the MAG Annual Scientific Assembly will be conducted from 9 a.m. to 12 noon on Friday, November 21, 1975.

OPENING SESSION program will begin at 12 noon in Pageantry Hall of the Terrace Garden Inn, featuring a luncheon and speaker for participating physicians and their spouses. Welcoming remarks will be given by David A. Wells, M.D., president of the Medical Association of Georgia. The Rev. Thomas D. Bowers, pastor of St. Luke's Episcopal Church in Atlanta will offer the invocation. Nicholas E. Davies, M.D., chairman of MAG's Committee on Education will introduce Anne R. Somers, D.Sc. (honorary), who will give the Calhoun Lecture, titled, "Current Issues in Health Education." Dr. Somers is an associate professor in the Departments of Community Medicine and Family Medicine at the College of Medicine and Dentistry of New Jersey-Rutgers Medical School.

EDUCATIONAL PROGRAMS have been planned for spouses on Friday, November 21 from 2:30 p.m. to 4 p.m. in Pageantry Hall. Alfred A. Messer, M.D., research psychiatrist in Atlanta, will discuss "The Medical Marriage and Family—Psychological Elements." G. Douglas Talbott, M.D., medical director for the DeKalb Alcohol and Drug Programs will speak on "Alcohol and Drug Abuse Among Doctors—An Occupational Hazard." Following the presentations, Mrs. Phil C. Astin, Jr., president of the Auxiliary to the Medical Association of Georgia will moderate an open discussion with Drs. Messer and Talbott.

In addition, free time for Christmas shopping in Lenox Square and Phipps Plaza has been planned.

EDUCATIONAL TOUR OF THE ARTS will begin with a bus trip from the Terrace Garden Inn at 9:30 a.m., Saturday, November 22 with a brief drive through Atlanta's northwest residential area known for its beautiful homes, the Swan House and the Governor's Mansion. The tour will visit the Memorial Arts Center on Peachtree Street where you will be educationally guided by a docent through the art exhibit of your choice—either "The Modern Image" or "The West of Buffalo Bill" (a special bicentennial exhibition). You will be entertained by the Alliance Theater performers who will present a revue of the coming season's program in drama. Afterward, you will enjoy a glass of sherry with the actors and actresses. Next stop is Brennan's for lunch and a return to the Terrace Garden Inn by 1:30 p.m.

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FRIDAY, NOVEMBER 21

MORNING

9:00 to 12:00 General Registration
Scientific Session, American College of Physicians—Georgia

AFTERNOON

12:00 to 2:00 Opening Luncheon for all Physicians and Their Spouses
Plenary Session With Keynote Address

2:00 to 5:00 Scientific Sessions:
American College of Physicians—Georgia
American College of Surgeons, Georgia Chapter
Georgia Association of Pathologists
Georgia Neurological Association
Georgia Radiological Society
Georgia Society of Plastic Surgeons
Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter

2:30 to 4:00 Educational Program for Physicians' Spouses

EVENING

5:00 to 6:30 Receptions:
Georgia Thoracic Society
Medical College of Georgia Alumni

5:30 to 7:00 Reception, Emory University Medical School Alumni

6:00 Reception and Dinner, Medical College of Georgia, Class of '45

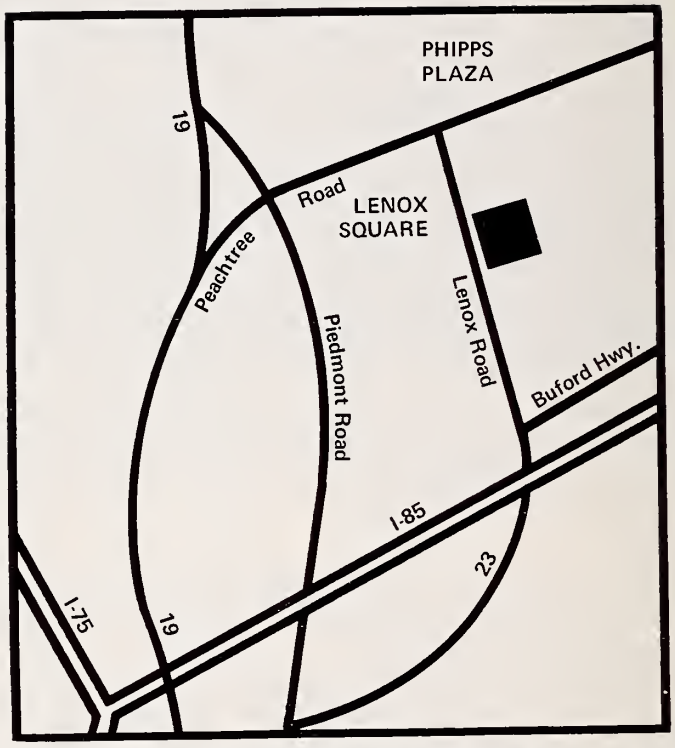
6:00 to 7:30 Reception, Tulane University School of Medicine Alumni

SATURDAY, NOVEMBER 22

MORNING

8:00 to 10:00 Business Meeting, Georgia Neurosurgical Society

8:30 to 12:00 Scientific Sessions:
Georgia Association of Pathologists
American College of Physicians—Georgia
Georgia Society of Ophthalmology



Location of Terrace Garden Inn, 3405 Lenox Road, N.E., Atlanta.

9:00 to 12:00 Scientific Sessions:
Georgia Gastroenterologic Society and American College of Surgeons, Georgia Chapter
Georgia Radiological Society
Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter

9:00 to 1:30 Spouses' Educational Tour of the Arts and Luncheon

10:00 to 12:00 Scientific Sessions:
Georgia Neurosurgical Society
Georgia Psychiatric Association

AFTERNOON

12:00 to 2:00 Luncheon and Educational Session, Georgia Society of Internal Medicine
Luncheon, Georgia Neurosurgical Society

2:00 to 6:00 MAGNET Conference

7:00 to 8:00 MAG Reception

Registration Form

MAG ANNUAL SCIENTIFIC ASSEMBLY
NOVEMBER 21-22, 1975
TERRACE GARDEN INN, ATLANTA

NAME: .....

ADDRESS: .....

SPECIALTY: .....

REGISTRATION FEE

Please check the appropriate boxes and add individual charges for the correct total:

- ☐ Member, Medical Association of Georgia $15.00
- ☐ Not a member of the Medical Association of Georgia 25.00
- ☐ Physician's Spouse 15.00
- ☐ American College of Physicians, Scientific Sessions (in addition to basic registration fee) 15.00
- ☐ Georgia Society of Internal Medicine Luncheon, Saturday 5.25

TOTAL ..... $ ____

Enclosed is my check for $....., payable to the Medical Association of Georgia.

I and/or my spouse plan to attend the following functions:

- ☐ Opening Luncheon on Friday. Number attending .....
- ☐ Spouses' Educational Program on Friday Afternoon
- ☐ Spouses' Educational Tour of the Arts and Luncheon on Saturday

I plan to attend the meeting(s) sponsored by:

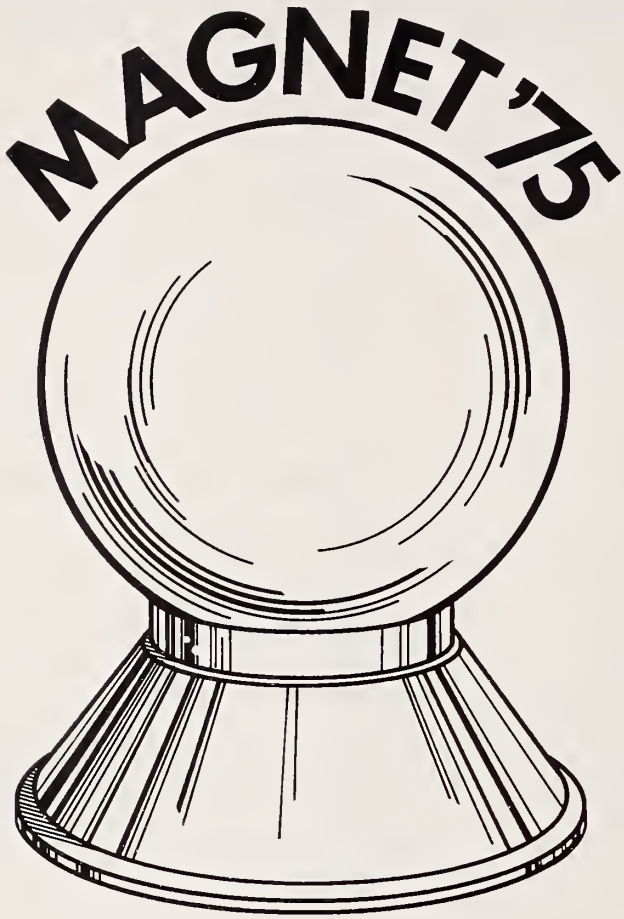
- ☐ American College of Physicians, Georgia
- ☐ American College of Surgeons, Georgia Chapter
- ☐ Georgia Neurological Association
- ☐ Georgia Radiological Society
- ☐ Georgia Association of Pathologists
- ☐ Georgia Society of Plastic Surgeons
- ☐ Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter
- ☐ Georgia Gastroenterologic Society
- ☐ Georgia Neurosurgical Society
- ☐ Georgia Psychiatric Association
- ☐ Georgia Society of Ophthalmology
- ☐ Georgia Society of Internal Medicine

Those intending to stay overnight in Atlanta from out of town should contact the Terrace Garden Hotel for reservations: 3405 Lenox Road, N.E., Atlanta, Georgia 30326, telephone (404) 261-9250.

MAG will help you coordinate your personal educational program. Please telephone the Headquarters Office at (404) 876-7535 or on the WATS line 1-800-282-0224.

Mail Registration Form to:

MAG SCIENTIFIC ASSEMBLY
938 Peachtree Street, N.E.
Atlanta, Georgia 30309



"The Future of Medical Practice"

November 22-23, 1975 • Terrace Garden Inn • Atlanta, Georgia

COMMUNICATIONS COMMITTEE Chairman Marvyn D. Cohen, M.D. has announced another "back to basics" program for the 1975 MAGNET Conference, scheduled at the Atlanta Terrace Garden Inn immediately following the Scientific Assembly.

Attendees at last year's conference were treated to a wide-ranging practice management program. Comments received from the over 250 participants after MAGNET 74 showed enthusiasm: "Most informative" . . . "I took 15 pages of notes" . . . "First meeting where I didn't fall asleep after lunch in years" . . . "Excellent program—the type thing MAG should be involved in."

MAGNET 75 will look at the future of medical practice as it relates to the situation today. Conference topics will include: solving Medicare problems, HSA update, professional liability, estate planning, and more. The program has been planned with the whole practice in mind. We urge you to bring your staff and advisors—accountants, attorneys, business managers, etc. MAGNET 75 will be an excellent idea exchange for all.

To help defray expenses, there will be a registration fee of $20 for each MAG member and $10 for each advisor or guest.

Alumni Events

FRIDAY, NOVEMBER 21

5:00 to 6:30 Medical College of Georgia
Alumni Reception
Pageantry Hall East

5:30 to 7:00 Emory University Medical School
Alumni Reception
Camellia Room

6:00 to 7:30 Tulane University Medical School
Alumni Reception
Magnolia Room

6:00 Medical College of Georgia
Reunion of the Class of '45
Reception and Dinner
Pageantry Hall West

SATURDAY, NOVEMBER 22

12:00 to 2:00 Medical College of Georgia
Alumni Luncheon
Newport Hall II
Rodeway Inn

Scientific Meetings

American College of Physicians, Georgia

FRIDAY, NOVEMBER 21

8:00 Camellia Room
Registration

8:45 Morning Session
Introduction: Edwin C. Evans, M.D., F.A.C.P. presiding, Governor for Georgia of the American College of Physicians

9:00 "Significance of Myocardial Infarction After Coronary Artery Bypass Grafting"

Arthur Merrill, Jr., M.D., Michael Hinne, M.D., Charles Thomas, M.D., Elliot Schechter, F.A.C.P., Emory Univ. School of Medicine, Wilford Hall, USAFB, Lackland, Texas

Discussion: Joseph Turner, M.D., Tifton

9:15 "Differentiation Between Hypothalamic and Adenohypophyseal Hypothyroidism with Thyrotropin Releasing Hormone (TRH) Infusion"

Don W. DeBra, Jr., M.D., Univ. of Rochester School of Medicine and Dentistry, N.Y.

Discussion: John Wolff, M.D., Atlanta

9:30 "National Gonorrhea Therapy Monitoring Study"

H. W. Harris, M.D., R. E. Kaufman, M.D., R. E. Johnson, M.D., C. Thornsberry, Ph.D., G. H. Reynolds, Ph.D., P. J. Wiesner, M.D., Cooperative Study Group, Center for Disease Control, Atlanta

Discussion: R. E. Dubois, M.D., Atlanta

9:45 Report of the Official College Representative George W. Pedigo, F.A.C.P., Louisville, Ky., Regent, American College of Physicians

10:15 Coffee Break

10:45 Presiding: Joseph Wilson, M.D., President, Georgia Society of Internal Medicine

"Clinical Signs of Streptococcal Pharyngitis in Adults"

Alan O. Feingold, M.D., Decatur

Discussion: Frank O. Evans, M.D., Milledgeville

11:00 "An Approach to the Rapid Diagnosis of Consumptive Coagulopathy"

Kenneth Alonso, M.D., Riverdale

Discussion: Norma Price, M.D., Atlanta

11:15 "Energy Cost and Hemodynamic Effects of Calisthenic Activities Used in Training of Post Myocardial Infarction Patients"

Axhar Faruqui, M.D., Edward Watt, John Cantwell, F.A.C.P., and Gerald Fletcher, F.A.C.P., Dept. of Medicine, Georgia Baptist Medical Center and Emory Univ. School of Medicine

Discussion: Edward Waxler, M.D., Waycross

11:30 "Arthritis Associated with Inflammatory Bowel Disease"

Colon H. Wilson, Jr., F.A.C.P., Assoc. Prof. of Medicine, Emory

2:00 Presiding: Nicholas E. Davies, F.A.C.P., Governor-Elect

Panel Discussion: "Medical Care, Medical Education, and the Internist"

Moderator: J. Willis Hurst, M.D., F.A.C.P., Prof. and Chairman, Dept. of Medicine, Emory

Panelists: Anne Somers, D.Sc., Assoc. Prof., College of Medicine and Dentistry of New Jersey, Walter B. Frommeyer, Jr., M.A.C.P., Distinguished Prof., Univ. of Alabama

3:30 Coffee Break

3:50 Presiding: Carter Smith, Jr., F.A.C.P., Program Chairman

"The Diagnosis and Management of Coronary Atherosclerotic Heart Disease"

1. "Definition of Syndromes": J. Willis Hurst, M.D.
2. "Recognition and Medical Management of Coronary Atherosclerosis": Bruce Logue, F.A.C.P., Prof. of Medicine, Emory
3. "Coronary Arteriography": Spencer B. King, F.A.C.P., Assistant Prof. of Medicine, Emory
4. "Surgical Treatment of Coronary Atherosclerosis": Charles R. Hatcher, M.D., Prof. of Surgery (Thoracic), Emory

SATURDAY, NOVEMBER 22

8:00 Registration and Exhibits

8:30 Presiding: Henry Jennings, Jr., M.D., Gainesville

"Newer Syndromes in Cardiology"
J. Willis Hurst, M.D.

House Staff Presentations—Dept. of Medicine, Emory

9:30 "Echocardiographic Diagnosis of the Flail Aortic Leaflet Syndrome"

Robert L. Whipple, M.D.

Discussion: Iverson W. Joines, II, M.D., Atlanta

9:45 "Host Immune Responses to Disseminated Gonococcal Infections"

Sumner E. Thompson, M.D.

Discussion: Andrew H. Abernathy, III, M.D., Atlanta

10:00 "Hemodynamic Evaluation of Porcine Xerograft Aortic Valve"

Douglas C. Morris, M.D.

Discussion: Hurley Jones, M.D., Brunswick

10:15 "Cardiac Features of an Unusual X-Link Hemeroperoneal Neuromuscular Disease"

Donald O. Nutter, F.A.C.P., Prof. of Medicine (Cardiology), Emory

10:30 Coffee Break

11:00 Remarks by Official College Representative, George W. Pedigo, F.A.C.P., Regent, American College of Physicians, Louisville, Ky.

11:15 "Pancreatic Disease in Patients with Alcoholic Cirrhosis"

SPOUSES OFFERED EDUCATION AT MAG SCIENTIFIC ASSEMBLY

One of the innovative aspects of MAG's 1975 Scientific Assembly on November 21-22 in Atlanta is that physicians' spouses will have their own educational programs. Highlighting Friday afternoon's program for spouses will be a timely in-depth discussion of "Special Problems in the Doctor's Family." Saturday's program will feature an educational tour of the arts at the Memorial Arts Center.

The principal speakers for Friday's program are Doctors Alfred A. Messer and G. Douglas Talbott. Dr. Messer, a well-known Atlanta psychiatrist and author of a number of books and articles on family problems, will address the topic "The Medical Marriage and Family—Psychological Elements." Dr. Talbott, a cardiologist and addictionologist who recently moved to Georgia from Maryland in order to become Director of the DeKalb Alcohol and Drug Programs, will treat the subject "Alcohol and Drug Abuse among Doctors—An Occupational Hazard." In September, 1975, the MAG gave full support to a Disabled Doctors Program, which Dr. Talbott designed and will direct. This is the first state medical program for disabled doctors which includes treatment along with identification of those doctors afflicted with the disease of addiction. Members of the audience will have ample opportunity to engage in open discussion with Doctors Messer and Talbott.

The educational program on Saturday includes activities in art and drama. Docents will guide small groups through educational tours of two art exhibits at the High Museum—"The Modern Image" and a special bicentennial exhibition entitled "The West of Buffalo Bill." Then the Alliance Theater players will present a Revue of the coming season's dramatic productions. Afterward program attendees will have the opportunity to enjoy a glass of sherry backstage with the actors and actresses. The morning's activities will be topped off with lunch at Brennan's.

A registration fee of $15 will cover all activities for spouses on both days (including the lunch at Brennan's). Registration forms have been mailed to all physician members of the MAG, but for your convenience the same form is provided elsewhere in this issue of the *Journal*.

Hans Adams, M.D.

Discussion: Brantley Burns, M.D., Atlanta

11:30 "Experience With Endoscopic Retrograde Cholangiopancreatography"

Joseph Griffin, M.D., David Mainz, M.D.

Discussion: J. Scott Fantz, M.D., Atlanta

11:45 "Cardiac Arrhythmias in Patients With Respiratory Failure Due to Chronic Obstructive Pulmonary Disease"

Cullen Rivers, M.D.

Discussion: Jonne Walter, M.D., Atlanta

12:00 Luncheon—Georgia Society of Internal Medicine

American College of Surgeons, Georgia Chapter

FRIDAY, NOVEMBER 21

2:00 to 5:00 Rosewood Room

2:00 to 3:15 Presentation of essays by selected residents in surgery from the state of Georgia in competition for $200 prize award

3:30 to 5:00 Panel Discussion
"Post-Gastrectomy Problems"

Moderator: W. Dean Warren, M.D.
Chairman, Department of Surgery
Emory University School of Medicine

Panelists:
William McGarity, M.D.
Professor, Department of Surgery
Emory University School of Medicine

Arlie Mansberger, M.D.
Chairman, Department of Surgery
Medical College of Georgia

John P. Wilson, M.D.
Surgeon, Atlanta

J. Richard Amerson, M.D.
Professor, Department of Surgery
Emory University School of Medicine

SATURDAY, NOVEMBER 22

9:00 to 11:30 Rosewood Room
Joint meeting with the Georgia Gastroenterologic Society (See that program)

Georgia Neurological Association

FRIDAY, NOVEMBER 21

2:00 to 3:30 Mimosa Room
"The Pharmacology and Treatment of Extrapyramidal Disorders"

Dr. Harold L. Klawans, Jr.
Director, Division of Neurology
Michael Reese Medical Center
Chicago

3:30 Business Meeting

Georgia Radiological Society

(This meeting of the Georgia Radiological Society is dedicated to the memory of R. Dale Cooper, Jr., M.D. (1934-1975).)

"THE RADIOLOGY OF TRAUMA"

FRIDAY, NOVEMBER 21

2:00 to 5:00 Magnolia Room

2:00 Introductory Remarks
Gerald E. Chaplan, M.D., President, Georgia Radiological Society

2:05 *In Memoriam,* R. Dale Cooper, Jr., M.D.
Parry Soder, M.D.

2:10 "The Differential Diagnosis of Traumatic Lesions of the Occipito-Atlanto-Axial Segment"
Robert Shapiro, M.D., Clinical Professor of Radiology, Yale University; Chairman, Department of Radiology, Hospital of St. Raphael

2:55 Questions

3:00 "The Radiology of Skull Trauma"
Joseph Marc, M.D.

3:45 Questions

4:00 "Traumatic Lesions of the Cervical Spine Below C2"
Robert Shapiro, M.D.

4:45 Questions

5:00 Adjournment

SATURDAY, NOVEMBER 22

9:00 to 12:00 Magnolia Room

9:00 "The Place of Arthrography in Knee Injuries"
Fred L. Allman, Jr., M.D., Orthopedic Surgeon, Atlanta
S. Boyd Eaton, M.D., Radiologist, Atlanta
Peter J. Sones, M.D., Radiologist, Atlanta

10:10 GI and GU Trauma: A Film Interpretation Panel
Moderator: Jerry Domescik, M.D.

11:00 Business Meeting

Georgia Association of Pathologists

FRIDAY, NOVEMBER 21

2:00 to 5:00 Wisteria Room

2:00 "Pitfalls in Lead Analysis"
Dennis Cox, M.D.

2:20 "Erythrocyte Protoporphyrin Determination in Blood"
J. J. Chisholm, M.D.

2:50 Discussion

3:00 "Effect of Drugs and Pesticides on Normal and Atypical Cholinesterase (Plasma and Red Blood Cell)"
Edward Baker, M.D.

3:15 Break

3:30 "Drug Interactions"
Peter Dayton, M.D.

3:55 Discussion

4:00 "Toxicology of Selected Environmental and Other Toxic Substances"
Renate Kimbrough, M.D.

SATURDAY, NOVEMBER 22

8:30 to 12:00 Wisteria Room

8:30 "Application of Mammography to Surgical Specimens"
Lester Forbes, M.D.

8:50 "Thyroid Function Tests in Women: Pregnant, Non-Pregnant and 'On the Pill' "
Robert S. Donner, M.D., John Souma, M.D., and Paul Green, M.D.

9:10 "Cytological Studies in Surgical Pathology"
John T. Godwin, M.D.

9:30 "Lipoprotein Electrophoresis"
Gerald Cooper, M.D.

10:00 Break

10:20 "Melanoma"
Wallace Clark, M.D.

Georgia Society of Plastic Surgeons

"RECONSTRUCTION BREAST SURGERY WITH OR WITHOUT CANCER"

FRIDAY, NOVEMBER 21

2:00 to 5:00 Raintree Room

2:00 "Lymphedema of the Upper Extremity Following Radical Mastectomy"
Stephen R. Lewis, M.D., Chairman, Department of Plastic Surgery, University of Texas Medical Branch, Galveston, Texas

2:20 "Nipple Reconstruction"
Benjamin Wofford, Jr., M.D., Marietta

2:40 "Breast Reconstruction Following Radical Mastectomy"
Stephen R. Lewis, M.D.

3:00 "Reduction Mammoplasty"
Ronald Freeman, M.D., Macon

3:30 "Mastopexy"
Stephen R. Lewis, M.D.

3:40 "Augmentation Mammoplasty"
Joseph M. Still, M.D., Department of Surgery, Medical College of Georgia

4:00 "Subcutaneous Mastectomy With Immediate or Delayed Augmentation"
Stephen R. Lewis, M.D.

4:20 Panel Discussion, "Plastic Surgery of the Breast"
Moderator: Lovic W. Hobby, M.D.
Panelists: Stephen R. Lewis, M.D., Joseph M. Still, M.D., Ronald Freeman, M.D., Benjamin Wofford, M.D.

Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter

"IMMUNOLOGICAL ASPECTS OF PULMONARY DISEASE"

FRIDAY, NOVEMBER 21

2:00 to 5:00 Dogwood Room

2:00 Introductory Comments:
Robert DiBenedetto, M.D., Clinical Assoc. Prof. of Medicine, MCG, Augusta; Dir. of Pulmonary Disease Section, Memorial Medical Center, Savannah

2:05 "Basic Immunological Reactions Applied to Pulmonary Diseases—Types I, II, III, IV"

Raymond G. Slavin, M.D., Prof. of Medicine; Dir., Section of Allergy and Immunology, St. Louis Univ. School of Medicine

2:55 Question and Answer Period

Note: Physicians are urged to submit questions either in writing or orally at each panel discussion and question and answer period.

3:05 "Experimental and Immunological Aspects of Hypersensitivity Pneumonia"

Jordan N. Fink, M.D., Prof. of Medicine; Chief, Allergy Section, Medical College of Wisconsin

3:35 Question and Answer Period

3:40 Coffee Break

3:50 "Immunological and Therapeutic Aspects of Sarcoidosis"

Louis E. Siltzbach, M.D., Clinical Prof. Emeritus of Medicine; Director, Sarcoidosis Laboratory, Mount Sinai School of Medicine of the City of New York

4:50 Question and Answer Period

5:00 Conclusion

5:00 to 5:30 Business Meeting
Dogwood Room

5:30 to 6:30 Reception
Dogwood Room

SATURDAY, NOVEMBER 22

9:00 "Clinical Aspects of Hypersensitivity Pneumonia Prototype Pigeon Breeder's Disease"

Jordan Fink, M.D.

9:50 Question and Answer Period

10:00 "Natural History of Sarcoidosis"

Louis Siltzbach, M.D.

10:30 Question and Answer Period

10:40 "The Spectrum of Pulmonary Aspergillosis"

Raymond Slavin, M.D.

11:20 Question and Answer Period

11:25 Coffee Break

11:35 "The Place of the Kveim Reaction in the Diagnosis of Sarcoidosis"

Louis Siltzbach, M.D.

12:00 Panel Discussion
Robert DiBenedetto, Moderator
Panelists: Raymond Slavin, M.D., Jordan Fink, M.D., Louis Siltzbach, M.D.

12:30 Conclusion

Georgia Neurosurgical Society

SATURDAY, NOVEMBER 22

8:00 to 12:00 Rosewood Room

8:00 to 10:00 Business Meeting

10:00 "The EMI Scan"

James Hoffman, M.D.

10:30 "Rationale for Anterior Decompression and Posterior Stabilization in Fractures of the Thoracolumbar Spine"

Thomas E. Whitesides, Jr., M.D.

11:00 "Current Concepts of the Pathophysiology of Trigeminal Neuralgia"

Nettleton S. Payne, II, M.D.

11:30 "Intracranial Pressure Monitoring in Closed Head Trauma: Is It Indicated?"

Alan S. Fleischer, M.D.

12:00 "Criteria for Brain Death"

Floyd Haar, M.D.

12:30 to 1:30 Luncheon
The Plymouth Suite, Rodeway Inn

Georgia Society of Ophthalmology

SATURDAY, NOVEMBER 22

8:30 to 12:00 Peachtree Parlor 2 and 3, Rodeway Inn

8:30 "Laser Mydriasis"

Alvin W. North, M.D.

9:00 "Comparative Intraocular Pressure Effects of Adsorbo Carpine and Isopto Carpine"

Tom Harbin, Jr., M.D.

9:20 "Pars Plana Lensectomy and Vitrectomy with the Douvas Roto Extractor in Diabetic Retinopathy"

John A. Davidson, M.D.

9:40 "The Prognostic Significance of Retinal Starfolds in Retinal Detachment"

William S. Hagler, M.D. and William H. Jarrett, II, M.D.

10:00 "New Techniques in Cosmetic Blepharoplasty"

Clinton D. McCord, Jr., M.D.

10:20 Coffee and Coke Break

10:40 "Dermoid Tumors in Children"
Zane F. Pollard, M.D.

11:00 "Leukemic Involvement of the Anterior Segment of the Eye"

Leon R. Gross, M.D.

11:20 "Primary Open-Angle Glaucoma in Young Adults"

John F. Bigger, M.D.

11:40 "Quickert Operation for Treatment of Acquired Ptosis Due to Levator Dehiscence"

Howard L. Bruckner, M.D.

Georgia Gastroenterologic Society and American College of Surgeons, Georgia Chapter

SATURDAY, NOVEMBER 22

9:00 to 12:00 Pageantry Hall West

9:00 "Endoscopy in Post-Gastrectomy Problems"

Francis B. Milligan, M.D., Endoscopist-Gastroenterologist, Johns Hopkins University Medical School

10:00 Case report by a Fellow in Gastroenterology from Emory University

10:15 Discussion, moderated by E. Napier Burson, M.D., Atlanta

10:45 Coffee and Coke Break

11:00 "Colonoscopy"

Francis B. Milligan, M.D.

11:45 Case report by a Fellow in Gastroenterology from the Medical College of Georgia

Georgia Psychiatric Association

SATURDAY, NOVEMBER 22

10:00 to 12:00 Pageantry Hall East

"Malpractice: Why You Might Get Sued and What You Can Do About It"

Discussants: Sheldon Cohen, M.D., practicing psychiatrist, Atlanta; Jonas Robitscher, M.D., Ph.D., Henry R. Luce Professor of Law and the Behavioral Sciences, Emory University; Paul Cadenhead, attorney

Georgia Society of Internal Medicine

SATURDAY, NOVEMBER 22

12:00 to 2:00 Newport Hall I, Rodeway Inn
Luncheon and Program
"Projections on Future Federal Health Legislation"

Speaker: William R. Felts, M.D., President-Elect, American Society of Internal Medicine, Washington, D.C.

The role of the Association is to serve as a catalyst, encouraging and helping physicians make use of all educational opportunities.

The MAG and Education

STEPHEN L. DANIEL, Ph.D., *Atlanta**

DOCTORS ARE HUMAN. Though their prodigious efforts to keep us healthy sometimes make them seem more than human, continual contact with people exposes their very human need for continuing education and assessment of the quality of their practice. According to a recent poll, medicine remains the most respected profession in the country. Yet no other profession demands such persevering efforts in order to retain this respect.

The above remarks will provide a context for what I have to say about the Medical Association of Georgia and education. It is estimated that over two-thirds of the physicians in Georgia are members of the MAG, and it therefore devolves upon the MAG to shoulder a large part of the responsibility for the final and longest segment of the doctor's educational continuum. This continuum extends from the first day of medical school, through residency training, and, beyond that, into a lifetime of learning in the service of man. Ideally the doctor who has finished his formal training will make sure that he gets all the continuing education he needs. But who of us in the real world cannot use a little help from friends? The question then should be: What is your medical association doing to help you further your education?

Under dynamic leadership over the past five years, the MAG's Education Committee has emerged as one of the association's largest and most active committees. There are presently 33 committee members, serving variously on four subcommittees: Continuing Medical Education, Accreditation, Medical Schools, and Public Education. These physicians, drawn from around the state, represent both private practice and academic medicine. In 1974 MAG's educational effort took a forward bound when the Education Committee was instrumental in the creation of a new position at the MAG office—that of Director of Education. Since last October it has been my privilege to hold this position, and every week brings new challenges and projects as I work with the doctors who comprise MAG's educational team.

* Assistant Executive Director for Education of the Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta, Ga. 30309. His Ph.D. in Humanities is from Emory University.

Priorities

Few will dispute that continuing medical education for practicing physicians should be the top priority in MAG's educational work. However, the field of CME is rapidly becoming a vast and diversified one, and we have found it necessary to establish priorities *within* CME.

The doctor with a busy practice does not often find time to attend clinical conventions in San Francisco, Miami, or even Atlanta. Nor is the personal benefit from his perusal of medical journals and audiovisual materials always clear. MAG's educational leaders are convinced that the local hospital is the best environment for CME because it is there that the doctor spends a good deal of his time not only visiting his patients but conferring with his peers. We have found that it often takes no more than one enthusiastic doctor and several cooperative colleagues to mount a hospital CME program of genuine quality and practical value. It may start as an informal journal club and evolve into a sophisticated weekly educational conference for the hospital staff. Starting something is always difficult, of course, but MAG's education team has devoted enough time and energy to the study of hospital CME programs to have a good idea of what the problems are and how they can best be solved. We are therefore able to provide consultation and sponsor workshops in such areas as the following: establishing educational objectives, planning and organizing programs, assessing educational needs through such means as patient care evaluation, identifying educational resources (including visiting educators), and evaluating the success of specific CME activities.

Accreditation Program

MAG's program of accreditation is a visible sign of its commitment to the encouragement of CME

activities in hospitals. The AMA has delegated the MAG to be its accrediting agent for those medical institutions in Georgia whose CME programs are of demonstrated worth. To insure this quality, MAG sends a survey team of physicians and MAG staff to the hospital to spend a day interviewing key personnel and observing actual education in progress. This team then makes its report to the Education Committee for final approval of accreditation. Doctors are increasingly finding CME accreditation important as they are called upon to render an account of their continuing education to colleagues, hospital authorities, and the public.

Another avenue of CME is the medical specialty society, voluntary health organization, or county medical society, whose principal ends usually encompass the sponsoring of professional education activities. MAG has an accreditation program designed uniquely for such organizations. In addition, MAG's new Scientific Assembly, to be held every November beginning this year, provides a convenient forum and speakers' funds for individual groups to put on their educational programs. This year, for instance, will find the members of 13 specialty societies participating.

MAG's Division of Education is also in the midst of establishing an Educational Resource Bank, a kind of speakers bureau whose function is to bring together physician groups seeking education and the potential providers of that education. Educational topics based on real needs will be selected at the local level (by a hospital staff, for example) and the MAG will supply the names of the appropriate educators who have been carefully selected for their knowledge and teaching ability by the medical schools, specialty societies, and voluntary health organizations.



The AMA's certificate of accreditation is presented to James L. Achord, M.D. (R), director of continuing education at the Medical Center of Central Georgia in Macon by Dr. Stephen L. Daniel, MAG assistant executive director-education.

It is not the MAG's intention to compete with the medical schools and other medical organizations in the actual provision of medical education. Indeed, we view our role as that of a catalyst, encouraging physicians to make use of the educational opportunities available throughout the state. If we have done our job well, the professional medical educators will have all they can do to keep up with the demands for their talents.

For over a decade the MAG and the medical schools have made a concerted effort to avoid the town-gown schism in the medical profession. A biennial education conference, co-planned and co-sponsored, creates the environment in which practicing physicians can ask their academic counterparts their burning questions about professional medical education, and vice versa. As one hospital-based physician educator put it recently, this conference can be the "moment of truth" for the medical schools and the private practitioners. Macon will be the site of the 7th Biennial Education Conference on March 5-7, 1976.

The Individual Doctor

Since the MAG exists primarily for the benefit of its members, we must never lose sight of the individual physician in our educational efforts. Obtaining CME in Blairsville or Blackshear, of course, presents problems different from those encountered by the physician in Atlanta or Augusta who tries to keep abreast of his field. MAG's Division of Education is prepared to help the physician tailor an educational program which will best meet his needs and resources. In this regard, my office is fast becoming a storehouse of information about audiovisual programs, educational techniques, medical library services, self-assessment exams, and the like.

We will be publishing regularly a medical meeting calendar to help doctors plan their education by keeping track of the numerous meetings in and around the state. In a recent issue of the MAG *Journal* we provided a Continuing Medical Education Record, which the physician can keep at home or in his office to record his CME activities and, if he so desires, to make application for the AMA's Physician's Recognition Award.

Educating Others

The ultimate aim of medical education is good health for all of us. The educational strand in the elaborate tapestry of health is made up of distinct but interwoven fibers: physician education, education of non-physician members of the health care

team, patient education, and public health education. Although the MAG understandably stresses the continuing education of its own members, it should also have a role in the education of others. Physicians are singularly qualified not only to serve as health educators, which they may not have the time for, but to offer professional advice on the scientific value and practicality of health education provided by others.

Members from a number of committees within the MAG have taken the initiative in attempting to upgrade all forms of health education in the state. This work includes such projects as the following:

1. Evaluating the basic training programs in Georgia for physicians' assistants, nurses, and emergency medical technicians
2. Co-sponsoring continuing education programs for physicians' assistants
3. Using the media to educate both doctors and the public about venereal disease as a public health problem
4. Promoting special education in prenatal and postnatal care for mothers
5. Reviewing and evaluating programs of patient education in such areas as diabetes, heart disease, and stroke
6. Promoting preventive medicine by collaborating with educators in the design of health curricula in the schools
7. Working to coordinate and evaluate the public health education activities of the voluntary health organizations

It appears that future projects along these lines will be limited only by the imagination and energy of MAG members who see the need to get involved.

Conclusion

In many ways the MAG's educational activities are those of a fledgling, curious to explore an unfamiliar world. Yet, in my work I have received the distinct impression that the MAG is beginning to distinguish itself among state medical associations for the extent and enthusiasm of its members' involvement in education. Knowledge maketh a bloody entrance, I was once taught to believe. But now, within a life-giving and life-saving context for education, and working alongside people who care as much about their own education as about that of their peers and patients, I have come to see the metaphor in a different light. Education is not a blow to the head from some sharp-edged instrument to allow for the intrusion of cold facts from the outside. It is rather, as its etymology implies, the sometimes messy but always joyous bringing to life of that which was potentially within already and which wanted to get out and encounter the world of people. A century ago the Danish philosopher Soren Kierkegaard said that in order to live an authentic human existence, it is not enough simply to *be* oneself: one must *become* oneself everyday in a perpetual repetition of rebirth. This bit of wisdom applies especially to that facet of our lives which we call education.

The MAG is not neglecting its educational responsibility to its members and the citizens of Georgia. Indeed it cannot afford to. ■

HIGHLIGHTS OF EXECUTIVE COMMITTEE

September 13, 1975

National Health Service Corps Physician for Homer, Ga.: Approved the application from Georgia Mountain Planning and Development Commission, previously endorsed by the Banks-Jackson Medical Society, for two NHS Corps physicians for Homer, Ga.

Regional Health Insurance Meeting: Approved sending an MAG observer to attend this meeting sponsored by a coalition of state and local government organizations to insure that their interests will be understood and considered by Congress in the eventual debates on national health insurance.

Medicaid Lawsuit: Discussed the ramifications of bringing a lawsuit against DHR over the Medicaid Provider Agreement and Manual. Action deferred to Council.

Geriatric Committee: This committee, originally established to assist EMCRO, was disbanded since EMCRO has been phased out.

Establishment of MAG Prnting Service: Recommended to Council the establishment of a printing service for MAG, to provide savings for members as well as for in-house printing.

Ad Hoc Committee on Building and Lands: Reported that the committee is continuing its search for suitable facilities to headquarter the Association.

AMA Resolution 59 Regarding Geographical Fee Differential: Approved funds to send a representative to address the AMA Council on Medical Service on MAG's resolution in Chicago on September 27, 1975.

Appointments: Physicians Consultant Committee to Disabled Doctors Plan—G. Douglas Talbott, Decatur, chairman; John William Fristoe, Jr., Atlanta; Conway W. Hunter, Jr., Atlanta; A. John Mooney, Statesboro; Grover J. Brown, Lindale; Clyde B. Roundtree, Decatur; Joseph G. Bussey, Austell; William A. Futch, Conyers; F. Dempsey Guillebeau, Albany; Kenneth E. Shoemaker, Atlanta; and Bruce A. Elrod, Chattanooga, Tenn. (Ft. Oglethorpe, Ga.)

Advisory Council, Georgia Board of Nursing—J. Rhodes Haverty, Atlanta.



Dialogue participants (L-R) Stephen L. Daniel, Ph.D., Edwin C. Evans, M.D. and C. Daniel Cabaniss, M.D.

A Dialogue on Mandatory Continuing Medical Education

Continuing education has emerged in the last few years as a most important aspect of the medical profession. One of the biggest questions relating to continuing medical education (or CME) is whether or not it should be made mandatory. This is the topic of the following dialogue which took place on August 15, 1975, in Atlanta. Participants are Drs. Edwin Evans of Atlanta and Dan Cabaniss of Columbus, both members of MAG's Education Committee. Dr. Evans is a practicing internist, a former president of the American Society of Internal Medicine, and currently Governor for Georgia of the American College of Physicians. Dr. Cabaniss is a cardiologist and Director of Medical Education at the Medical Center in Columbus. He is the president of the Georgia Heart Association. Posing the questions is Stephen Daniel, MAG's Director of Education.

Dr. Daniel: I'd like to start the dialogue by describing the status of mandatory CME in the United States. This will provide us a background for raising some questions and issues.

There are various forms of mandatory CME, as you know. One of these is the requiring of attendance at continuing education activities for re-licensure in the state where one practices. There are now six states with such a requirement. New Mexico, the first to implement the requirement, requires 120 hours of CME over a three-year period.

Another route for mandatory CME is recertification, and this is handled through the specialty boards. For instance, the American Board of Family Practice now requires 150 hours of CME over a three-year period for recertification in Family Practice. The year 1976 will mark the ABFP's first mandatory recertification exam.

Mandatory CME can also take the form of a requirement for membership in various organizations. For instance, the American Academy of Family Physicians requires 150 hours every three years. Also, 12 state medical associations require CME for membership. Among them are our neighbors Florida, Alabama, and North Carolina.

With this background, I would like to ask each of you to comment on several of the big questions which have come up in discussions of mandatory CME. First, what are the pressures at work in promoting mandatory continuing education as you see it? Do these pressures come from inside or outside the medical profession?

Mandatory CME Pressures

Dr. Evans: I think that everyone is aware of the information explosion and the rapidity with which medical information becomes obsolete. It is said that the half-life of medical knowledge is from five to seven years. This implies that a physician who is up-to-date now will be totally out-of-date by 1985 unless he continues his education. So, it's absolutely necessary for one to have continuing education to keep

up with the latest information and to turn this information into knowledge. Knowledge, however, is only the first step toward delivering quality medical care. One also has to convert knowledge into competence, cognitive skills, and adequate performance. The pressures for continuing education are the realization by the profession, by the public, and by politicians and government particularly that it's absolutely necessary for us to keep up to maintain our provision of quality medical care. Therefore, there should be CME, and there are pressures to make it mandatory, but I don't think it should be mandatory.

Dr. Cabaniss: I don't think there is any question that the pressures are societal and governmental, as Dr. Evans pointed out; it's in vogue now for public bodies to examine the medical profession very critically. But I think there are many pressures within the profession. For instance, the American Academy of Family Practice, well before these societal and governmental pressures, made CME a requirement for membership. This is a healthy sign of an emerging specialty. I think that 90 per cent or greater of physicians make the effort they should to get CME. But is it worthwhile to make attempts to educate the 10 per cent or less who don't make voluntary efforts? Then I think the other question that should be addressed at great length by physicians is methodology.

The AMA listed over 3,600 CME courses for 1974-75. It would be interesting to find out the relevance of these courses to the physicians in practice. I remember the story of the young county agent who went to the old farmer and gave him pamphlets about how to till and how to fix his hills so they wouldn't wash away. And the old farmer said, "Son, don't bother me with that; I already don't farm as well as I know how." I wonder whether physicians should be solely concerned with acquiring new information and being on the cutting edge of medicine. Maybe we ought to be looking harder to see that we do the things which we do every day as well as we possibly can, as well as acquiring new information.

Dr. Daniel: Should the small percentage of physicians who don't make the efforts to continue their education be forced to do so?

Dr. Cabaniss: Very frankly, I think CME should be mandatory. The medical profession may show the way to other professions which deal in public trust, and one way to demonstrate that we respect the public trust is to demand basic educational requirements. If we establish minimum criteria, I don't see how this will work a great hardship on physicians. I am not sure whether the best means of achieving this is recertification, relicensure, self-assessment, or something else. A valid methodology has yet to be found.

Performance Counts

Dr. Daniel: Dr. Evans, what do you think about requiring CME?

Dr. Evans: I agree with Dan that the great majority of our physicians are participating in CME, and certainly this should continue. At the present time I'm against making it mandatory because of methodology more than anything else. As Dan has indicated, the performance of the physician in what he/she does every day is what we are really interested in. Do a wealth of information, all sorts of skills, ability to write pen-and-pencil examinations and self-assessment tests, and the attendance at meetings in attractive places indicate that the doctor is doing a good job? I think not, and there is evidence to support this idea. Yet these are the criteria we're presently using to assess CME. I don't feel that they truly document that the individual is delivering quality care. I'm opposed to mandatory CME, therefore, because we lack the method for demonstrating its effect on physician performance.

Dr. Daniel: In the absence of an adequate mechanism for measuring the effect of education on the quality of care provided by the physician, is it not possible that the government will come in and mandate CME in some form or another? Dr. William Roy, former congressman from Kansas, stated recently that national health insurance may require relicensure, recertification, or both, of participating physicians. Do you think this is a possibility?

Dr. Cabaniss: I think that it's an extremely unpleasant possibility, and unpalatable to me, that it should be legislated from outside the profession. This is a great stimulus for us to arrive at something that is palatable and workable. I have a lot of hope for in-house audit. I think medical audit is useful and may give us some measure of performance. If we do in-house audit on subjects, make certain findings and diagnoses, and hold educational sessions on the subject, then we can assess progress six months down the road by the method of re-audit. I think this is very useful if done educationally and in a nonpunitive fashion. What it has done, in my limited experience, is show that most doctors do a great job.

Dr. Daniel: You would still require continuing education?

Dr. Cabaniss: Right. Audit does not name names or point fingers. I think that audit committees generated by hospital staffs should require every physician whose chart appears in a particular audit to attend the session at which the audit is discussed. And if that's mandatory CME I think it's valid. If my chart were part of an audit, then I certainly would want to be there.

I think programs that come out of local hospitals are the real world. They measure a physician's per-

formance against that of his peers, but in his community and within his hospital, and I think these are the best received programs which you walk away from with the most learning.

Dr. Evans: Dan has put continuing education and peer review together in a package and I think that now, when you get down to this area, I would agree with him that CME should be mandatory. I agree that medical audit, as I've heard Dan say, is one of the best currently available ways to measure performance, which we are principally concerned with. Putting CME and audit together should be mandatory, and it's only when you try to use CME as a basis for membership in some organization outside of one's hospital that I'm opposed to mandatory CME.

Hospital Staff Privileges

Dr. Daniel: Would you be in favor of mandatory CME involving peer review for staff privileges at a hospital?

Dr. Evans: Yes. I would be in favor of mandatory CME based upon adequate peer review. Even as a basis for membership in the state medical association, I think I would favor mandatory CME *if* the CME was based mainly upon peer-review-identified needs and *if* the final decision for membership was based upon the physician's performance as determined by peer review. However, our peer review has not yet become so effective that it can be used on an all-encompassing basis in a practical manner to determine performance.

Dr. Cabaniss: I'm a recent convert. I was a heathen on the subject of audit, and just like a lot of heathens I became converted by participation in the particular religion. My objection to audit is that it has been a bit over-sold as the only method of CME. I think that audit ought to be the framework that we hang things on and the starting point, possibly, but I definitely think that if CME is to be effective, you've got to do more than tell physicians how well they're doing at the moment. You need to use audit as the take-off point and say, for example, this is the way we're treating ulcers today, but maybe tomorrow we should be treating them *this* way.

There's one other thing I want to say. We need to look to the medical schools for more leadership than we're getting in this area. I think that the leadership in audit and CME based on audit is coming out of the community hospitals, and I firmly believe that more medical school time and service and interest needs to be directed to this. I believe that medical school faculty need to look hard at their own performance, and then they can better teach performance to medical students. It's interesting that we have finally reached the point in medicine where the practicing physicians in the community hospitals have hit upon something that the medical schools have got to catch up with.

Dr. Evans: I agree. I feel that the future locus of continuing education is the community hospital. Educators agree that education is most satisfactory when it is experience-centered, that is, when it's built around the locale of the physician's practice with the one who is being educated participating actively in the educational process. At the present time education is more practicable in the physician's hospital than in his office. The hospital is an ideal place for problem-solving, an important element of effective education. And, since medical audit and education are both concerned with changing behavior through the method of problem-solving, I think audit is a genuine basis for CME. Through audit one finds out what he really needs to know and do to improve the quality of his performance and then designs a program to improve his behavior. There is a focus on the learner learning what he needs to know instead of on the teacher teaching what he thinks the learner needs to know. I think that the medical schools, and organizations like the American College of Physicians for that matter, should let it be known that they are ready to help in educational programs of community hospitals as they identify their educational needs.

Association Membership

Dr. Daniel: To shift to another form of mandatory CME, do you believe that the MAG should move in the direction of requiring CME for continued membership in the association?

Dr. Evans: No, I don't. As I've mentioned before, I do not believe it's worthwhile to make CME mandatory just to try to pick up the small percentage of people who are not interested in it. Maybe we'll get them, if we make CME mandatory, but I don't believe we'll improve the quality of care. Since the purpose of CME is to improve the quality of care, I don't feel we've gained anything by making CME mandatory.

Dr. Cabaniss: I'm not sure that CME as a requirement for membership in the state association is the proper route either. I think that if we made it a requirement, maybe the 5 or 10 per cent who don't participate in CME would drop out of the state society. It might run this deep with the people who refuse to participate. But I do believe that we ought to back efforts strongly at the local hospital level to require audit systems that will allow in-house evaluation of performance with feedback, educationally in a non-punitive fashion. I think the MAG's role should be to back a mandate that this be done in the proper fashion.

One of the next big questions is how we are going to adapt meaningful audit to office practice where 90 per cent of the primary care is done, because I think it's here that we need the most help and need to bend some of our real efforts.

Dr. Evans: At least 80 to 90 per cent of all the people who go to see doctors go to their offices to see them. This is where the audit belongs, as Dan brought out. In 1972 the American Society of Internal Medicine (ASIM) made the effort to do an office audit of a number of its member internists in four states, including Georgia, and learned a lot of things from it. In a 1975 survey of all board-certified internists in the U.S., over half of those surveyed felt that assessment of the physician's performance should be included in any method of recertification. As a result, the ASIM now has two pilot projects going on, one in Ohio and one in Connecticut, trying to refine the methods of assessing office performance. The ultimate idea is to allow the individual to request recertification voluntarily on the basis of an assessment of what he actually does. If we can combine the office assessment with the hospital audit, then we have a pretty fair method of assessing the total performance of the individual. If one qualified for recertification in this fashion, I would say he should be professionally qualified automatically for membership in his state medical society and for relicensure.

Dr. Daniel: To summarize, I take it that both of you are opposed to forms of mandatory CME which would not be directly related to educational needs and assessment of the quality of care which the physician delivers in his office and local community hospital. But if these elements were present, then each of you would be in favor of some form of educational requirement, although you may differ in the use of these requirements for membership in various organizations. Would each of you care to say a word by way of conclusion?

Conclusions

Dr. Cabaniss: I think we're really on our way. All you have to do is pick up the polyglot of CME and notice that recertification, membership in state societies, relicensure, etc., are all being grappled with by the medical profession. It's like a disease we have no cure for: there are 150 treatments, we're all working with it, and I think we're going to come up with some good answers. I'm heartened by audit, although I think it has shortcomings. It shouldn't be our only method, but I think it gives us a glimmer of promise.

I hope we can eventually arrive at some standards for excellence in our profession. There are so many excellent physicians, and there ought to be some recognition for their excellence. Right now one of the best ways of doing this, I think, is the AMA's Physician's Recognition Award. It's a non-coercive method of tabulating your CME and giving yourself a diagnosis about what you're doing. You can look at your three-year record, possibly mix in a voluntary self-assessment examination, and see the areas that you're weak in. Then you can go back to your record and see where you need to put emphasis.

The medical profession needs to do all of this voluntarily, because I think governmental and societal pressures are such that, very much like many other things we've been confronted with, if we don't do the job, somebody is going to inexpertly do the job for us.

Dr. Evans: The goal of all of us in medicine is to give the highest quality of medical care. Since the information explosion rapidly produces such a rapid obsolescence of current knowledge, the physician's knowledge, competence, and performance can only be maintained satisfactorily by adequate methods of continuing education. This education should be relevant, experience-centered, and focused more upon the learner than upon the program. Until mandatory CME has been demonstrated to upgrade significantly the quality of medical care, I am opposed to it as a requirement for membership in medical organizations. Recertification programs in the future should be based upon what the physician does in his daily practice, with less emphasis on other approaches, such as pen-and-pencil examinations and attendance at meetings. The medical profession, and I include MAG, should launch a strong program now to inform our colleagues, patients, the public, politicians, and government of the potential dangers of binding the hands of physicians in a legal process of relicensure based upon qualifications and data which have very little relevance to what should be the most important element in relicensure, namely, how the physician actually performs in his daily practice. Along with this forewarning, great emphasis should be placed upon the unique strides that the medical profession has made, and will continue to make, to assure the quality of care in this state and in this country through peer review. ■

Physical growth of the school, the development of new programs and curricula, and community involvements are reviewed.

Medical Education at Emory

THOMAS J. SELLERS, ***Atlanta****

At the end of the Second World War, the Emory University School of Medicine had only 45 full-time faculty members. Much of the clinical teaching was done by local physicians—a little over 200 in number—who comprised the volunteer faculty. Emory's medical reputation was largely regional.

Compare those years with today. Enjoying now a growing national and international reputation, the Emory medical school is involved in an extensive program of teaching, research, and service that involves approximately 1,700 faculty members and 1,000 medical students, interns, and residents.

The full-time paid faculty of the school today numbers about 600, and the volunteer faculty is close to 1,000. (There are also fellows and part-time teachers on the faculty.)

Annual expenditures of the school in the postwar era have climbed from less than $1 million to a figure approaching $25 million. Building programs on the Emory and Grady Hospital campuses in the same period have amounted to well over $100 million.

Record Enrollment

Over the last decade the number of young men and women seeking their M.D.'s at Emory has increased by over 50 per cent. In the M.D. program, the 441 medical students enrolled this fall represent by far the largest student body in the school's history, as Emory moves to keep pace with the vast and growing demand for physicians and allied health professionals in our society.

Emory-trained physicians and other health professionals are highly regarded in the worlds of both clinical and academic medicine.

The school is continually extending its program into areas beyond the bounds of traditional medical education to serve the student and society better. The central purpose of its program, however, remains the same as that of its earliest predecessor institution: to offer the best possible learning opportunities to young people who wish to qualify as physicians. As an adjunct to this end, the school established a Division of Allied Health Professions in September 1968 for the training of some of the top members of the modern physician's team.

Among the recent trends in medical education at Emory are the new Physician Associate Program and other allied health programs; community outreach programs such as the Columbus (Ga.) Medical Center teaching affiliation; increasing emphasis on the social, economic, and behavioral aspects of health care; a trend toward interdepartmental and interdisciplinary teaching; and more elective time for medical students, especially in the senior year.

Emory's Physician Associate (PA) Program, which got under way in 1971, admits about 40 new students each year. The program is composed of didactic and clinical training portions totaling 27 months in duration. The Emory-trained PA is capable of approaching the patient, collecting historical and physical data, organizing these data and presenting them in such a way that the physician can visualize the therapeutic steps. He or she (the PA) is also capable of assisting the physician by performing and coordinating the roles of other, more technical assistants.

Three types of degrees are offered in the Division of Allied Health Professions: Associate, Bachelor's, and Master's Degrees in Medical Science. In addition, a Certificate is offered in some fields. The 16 programs in which one or more such degrees or certificates are offered are Anesthesiology and Life Support Systems, Intensive Respiratory Care, and Respiratory Therapy Technician; Biomedical Information and Computer Science; Clinical Microbiology; Communicative Disorders; Dietetics; Health Record Administration; Immunohematology; Medical Record Administration; Medical Technology; Orthoptics; Physical Therapy; Physician Associate; Radiological Science, and Radiologic Technology.

Medical Curriculum

The curriculum for Emory medical students undergoes constant scrutiny and frequent revision to

* Science editor, Emory University, Atlanta, Ga. 30322.



An example of the interdepartmental and interdisciplinary approach in medical education at Emory: First year medical students at Emory University School of Medicine attend weekly clinics conducted by a faculty neurologist. The clinics are part of an interdisciplinary course in neurobiology and involve presentation of patients. Students are encouraged to arrive at their own diagnoses. Faculty from anatomy and physiology departments, as well as the neurology department, participate.

incorporate new knowledge and trends in medicine. This year, for example, Emory's 111 first-year medical students in the M.D. program will take a course entitled Introduction to Health and Medicine. In this course, now five years old, students will be given field experiences in the study material, and each student will follow a patient and family.

The first unit of Introduction to Health and Medicine is designed to give beginning students an overview of major problems in health and the health care system. Part of the course work involves participation of students in small group seminars with community physicians. A second unit focuses on the role of psychology in medicine: doctor-patient relationships, basic behavioral mechanisms, and human developmental sequence. A third unit relates physician and community and introduces the student to the epidemiologic method.

An example of how medical education today is integrating various disciplines is Emory's first-year Cellular Biology and Biochemistry, which uses basic texts from biochemistry, histology, and microbiology, as well as selected chapters from other texts. This course has replaced the traditional Biochemistry course for freshmen.

In his sophomore year the medical student is introduced to clinical medicine with an interdepartmental course called Clinical Methods. This course helps the student understand how basic science principles are applied to medical practice, and lays the foundation for the clinical work of the third and fourth years. It is here that the student learns to take the patient's history and do physical examinations.

All basic clerkships in the clinical health sciences are now given in the junior year, which has recently been expanded from 40 to 44 weeks in duration. Senior students get 20 weeks of elective studies in addition to a required eight weeks of medicine and eight weeks of surgery. During his five-month elective period, the senior student has a chance to explore areas of particular interest more deeply or to improve weaknesses he might have detected during his earlier medical school experience.

One feature of the elective program is the opportunity for Emory students to spend up to 12 weeks at another medical school. Seniors have studied at outstanding institutions such as Queen's Square in London, the University of Adelaide (Australia), Yale, Stanford, Texas-Southwestern, Tufts, Washington University, Rochester, and the Boston City Hospital.

Community Involvement

Emory has always been a friend of those in the community with health care problems, and the School of Medicine was a guiding force in the early years of the Atlanta Southside Comprehensive Health Center, which serves a large indigent population. In 1968, Emory went outside Atlanta to help develop the Emory-Columbus Medical Center Affiliated Program. This program has been credited with helping to improve health care services in the city of Columbus, Georgia, and its adjacent area by stimulating recruitment of new physicians and house staff at The Medical Center—a 530-bed city-owned community hospital.

The Emory-Columbus project is essentially a pro-

(Continued on page 385)

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gram in graduate and post-graduate medical education cooperatively carried out by the Columbus facility and Emory's School of Medicine. The Columbus Medical Center's director of medical education and chiefs of service hold faculty appointments in the medical school, and a number of other Columbus-area physicians are on the Emory faculty as well. "We believe this program will serve as a prototype for similar projects in other Georgia communities," says Dean Arthur P. Richardson of the Emory medical school.

Medical education at Emory is enhanced by the presence of a large patient population and numerous affiliated and supportive agencies. The School of Medicine is a division of the Woodruff Medical Center of Emory University—named for a family which has generously supported the development of health programs at Emory for many years.

In addition to the medical school, the Woodruff Medical Center contains seven other divisions of the university: the Division of Basic Health Sciences, the School of Dentistry, the Nell Hodgson Woodruff School of Nursing, Emory University Clinic, Emory University Hospital, Crawford W. Long Hospital, and the Yerkes Regional Primate Research Center.

Metropolitan Atlanta's 1.5 million people supply the large patient population necessary for medical education. And the medical complex surrounding the School of Medicine provides an excellent environment for medical education and research. The school's principal clinical teaching facilities are Grady Memorial Hospital, Emory University Hospital, Atlanta V.A. Hospital, Georgia Mental Health Institute, and Henrietta Egleston Hospital for Children.

Through its affiliated hospitals, the school offers intern and residency training in all divisions of medicine and surgery and their subspecialties, and in anesthesiology, gynecology-obstetrics, ophthalmology, pathology, pediatrics, physical medicine, psychiatry, and radiology. Senior faculty members of the Emory medical school are chiefs of the corresponding services at its teaching hospitals. These programs are recognized toward fulfillment of American Board requirements.

The School of Medicine is also involved in post-graduate or continuing education courses in the various medical specialties. These afford detailed coverage of individual subjects and vary in length from one day to one week. During the 1975-76 academic year, courses will be presented by the Departments of Anesthesiology, Gynecology and Obstetrics, Medicine, Ophthalmology, Pediatrics, Radiology, and Surgery. The school's continuing education program is fully accredited by the Council on Medical Education of the American Medical Association.

The dean of Emory's School of Medicine is the senior medical dean in the U. S., having the longest tenure of any medical dean now holding office. Dr. Richardson has held the post for 19 years and was previously director of the Division of Basic Health Sciences and chairman of the Department of Pharmacology at Emory. A native of Colorado who was reared in Hawaii, Dr. Richardson received his M.D. at Stanford in 1937. ■

ATLANTA RESTAURANT GROUP PLEDGES CIGARETTE SALE FUNDS TO HEART AND CANCER RESEARCH

Four Atlanta restaurants have joined in an effort to pledge funds collected in their cigarette vending machines and donate the proceeds to the Georgia Heart Association and the American Cancer Society, Georgia Chapter.

Called "Funds From Cigarettes," the campaign hopes to promote similar efforts in other states.

The program's beginnings came last year when Hank Soloff, owner of the Coach and Six restaurant and a victim of heart disease, decided to use the cigarette vending machine in his establishment to raise funds for cancer and heart disease control. The price was raised from 50 cents to $1, with a poster placed on top of the machine explaining how the proceeds would be used. Customer response was good and some $5,000 was raised in a year from the one machine. Mr. Soloff died two months after the program began.

His widow, Mrs. Beverly Soloff, now heads the Funds from Cigarettes Committee and has been joined by owners of Brennan's, The Midnight Sun and the Chateau Fleur de Lis who have pledged to donate proceeds.

Joining them at a press conference in September announcing the national campaign were J. Willis Hurst, M.D., professor and chairman of the Department of Medicine at Emory University School of Medicine, past president of the American Heart Association and chief of medicine at Grady Memorial Hospital; Hamblin Letton, M.D., past national president of the American Cancer Society; and Joel Goldberg, president of Rich's, Inc., and a leader of volunteer efforts to promote the campaign.

A primary goal of the new two-year medical program is to produce more primay care physicians for rural and inner city areas.

The Morehouse Medical Education Program

LOUIS W. SULLIVAN, M.D., *Atlanta**

The Atlanta University Center is a consortium of six institutions of higher education in the southwestern section of Atlanta. The total student enrollment of these institutions is in excess of 6,500. Morehouse College, one of these institutions, has an enrollment of 1,300 students and has a distinguished academic record. Morehouse College is one of the four institutions of higher education in Georgia with a Chapter of Phi Beta Kappa (the other three are Agnes Scott College, Emory University and the University of Georgia).

Over the years, Morehouse graduates have distinguished themselves in a number of occupations and professions, including medicine. Of the 6,000 black physicians in the United States some 450 (7.5 per cent) are Morehouse graduates. The college has always had a strong science program, including the bio-medical sciences. For example, 26 out of 27 of the pre-medical graduates of Morehouse in May 1975 were accepted into medical school.

The need for more physician manpower in Georgia was formally recognized in the 1969 Report of the Task Force for Physician Manpower to the Georgia Comprehensive Health Planning Council. The following recommendations were made:

1. "A study should be initiated at the earliest possible date to consider . . . the feasibility of developing a two year medical school," and
2. "Specific opportunities should be developed to provide for education of more black medical students."

Black Physician Ratio

In 1973, Morehouse College received a federal contract to investigate the feasibility of establishing a program in basic medical science education, i.e., a two year medical school. In the feasibility study it was noted that in Georgia there is one physician for every 926 people, but only one black physician for every 9,652 black people. Of the 97 black physicians in metropolitan Atlanta, 35 received their baccalaureate education at Morehouse College. Of the 36 black physicians in Georgia, outside the Atlanta region, 10 are Morehouse graduates. Thus, the feasibility study demonstrated a need for more black physicians in Georgia, as suggested by the Task Force Report in 1969, and further noted the significant contribution which Morehouse College has made to premedical education. Because of the inherent potential in the large number (6,500) of students enrolled in the institutions comprising the Atlanta University Center, with the encouragement received from local physicians, from the two medical societies in Atlanta, from the two state medical societies, from individuals in government and the private sector, and from foundations interested in medical education, Morehouse has undertaken the development of a new two year medical school.

The Morehouse Medical Education Program has received a grant from the Department of Health, Education and Welfare, to plan for the program in basic science medical education. The appointment of Louis W. Sullivan as Dean was announced in April of 1975. Dr. Sullivan was formerly Professor of Medicine and Physiology at Boston University School of Medicine and Director of Hematology at Boston City Hospital. The first class of 25 students will be admitted in September 1977. After completion of the first two years of medical studies, the students will transfer into the third class of affiliated four year medical schools. Thus far, discussions with the Schools of Medicine at Emory University, Howard University and Meharry have indicated an interest and capability of accepting third year students from the Morehouse Medical Education Program. Undoubtedly, by 1979, a number of other institutional options for transfer will be available to the Morehouse medical students. The long range plans of the Morehouse Medical Education Program call for its development into a four year, M.D.-degree

* Dean and Director of the Morehouse Medical Education Program, Morehouse College, 223 Chestnut St., S.W., Atlanta, Ga. 30314.

granting program, as rapidly as funds and facilities permit.

Medical Program Goals

The goals of the new medical program at Morehouse are as follows:

1. To produce more physicians to serve all of our citizens, especially our black and other minority citizens throughout the state
2. To produce more physicians for our rural areas and inner city ghettos, where there are presently too few, and often no, physicians
3. To train individuals who will become primary care physicians and family practitioners
4. To develop a medical education program of academic excellence
5. To advance the frontiers of medical knowledge through bio-medical research
6. To improve the health care of our citizens through the development of better mechanisms for health care planning organization and delivery
7. To develop a more viable interface between medicine, the humanities and the social sciences so as to produce physicians with a greater recognition of, and sensitivity to, the physical and emotional needs and interactions of their patients.

The curriculum of the Medical Education Program will be time-flexible, but competence constant. That is, by multiple curricula tracts, students will be able to complete their college and medical school studies in whatever time is optimal—7 years or 8 years, and in a few instances perhaps even 6 years. This will be accomplished by close integration of the undergraduate, premedical curriculum at Morehouse (and the other colleges in the Atlanta University Center) with the curriculum of the Medical Education Program—eliminating redundancies where possible and adding emphasis or reinforcement where needed or desirable. There will be a strong emphasis in the curriculum on primary care, preventive medicine, health education and community medicine, including preceptorships with practicing physicians in rural and urban areas who have an interest in and commitment to teaching medical students. It is planned that the curriculum will also include broad exposure to faculty research efforts (with opportunities for student participation). Self-instruction methods will be available, to increase the options for learning.

Whether the student in the Medical Education Program plans for a career as a primary care physician, teacher, researcher or health care administrator, the emphasis of the program will be on academic excellence. It is the philosophy of the program that the opportunities and challenges in each of these areas require the best efforts from our students and our faculty.

We are pleased and gratified by the support which has been received from the physicians in the State of Georgia. The Morehouse Medical Education Program looks forward to the continued support and participation of Georgia physicians in the development of this new medical school. ■

HIGHLIGHTS OF COUNCIL
September 13-14, 1975

MAG Newsletter: Authorized funds to produce a monthly all-member newsletter.

1975 MAG Yearbook: Reported a savings of $390 will be realized by deleting the Constitution and Bylaws from the Yearbook.

UR Regulations: Received a report that AMA's suit vs HEW regarding 24-hour admission review had been withdrawn inasmuch as HEW has withdrawn the requirement from the regulations.

PSRO Planning Contract Application: As directed by the House of Delegates in April, approved the submission of an application for a PSRO planning contract for Georgia. Any contract is to be submitted to the House of Delegates at its next session for final review before signing.

Medicaid Lawsuit: Heard a report from the president, David A. Wells, M.D. of the visit to Governor Busbee to discuss the Medicaid Provider Agreement and Manual. The committee came away from the meeting with the feeling that the Governor appreciated MAG's position but he explained that there was a definite problem with deficit spending. A subsequent meeting with Medicaid staff members indicated there would be no substantial modification of DHR's plan to implement the Agreement and Manual. The Council concluded that since there would be no modification in the Agreement or Manual, the only recourse was for MAG to file a lawsuit in federal court to seek relief. Legal costs will come from MAG's general funds and personal contributions.

CHEC Program: Received a report that the State had cancelled the Foundation CHEC Contract.

Disabled Doctors Plan: Approved the establishment of the Disabled Doctors Plan in Georgia and approved necessary funds.

MAG Printing Operation: Received recommendation of Exccutive Committee and approved an operation to provide printing services for MAG.

Professional Liability Insurance: Approved four recommendations of the Committee on Professional Liability Insurance for priority legislation, as follows: 1) establish an arbitrary system with voluntary binding arbitration; 2) identify collateral sources of payment; 3) eliminate *ad damnum* claims; 4) modify the statute of limitations. These are to be introduced at the next session of the Legislature.

PSRO: Agreed to send a MAG representative to Washington to testify before the subcommittee on Health of the Ways and Means Committee.

Next Meeting: January 10-11, 1976, Sonesta Hotel, Tower Place, Atlanta.

With first class admission two years away, Mercer University is busily securing funds, staff and facilities for its new medical school.

Mercer School of Medicine: Status and Plans

NAT E. SMITH, M.D., *Macon

MERCER UNIVERSITY IS DEVELOPING a four-year School of Medicine to help overcome the shortage of physicians in its region, particularly the shortage and unfavorable distribution of physicians rendering primary care services in Georgia.

Funds are being sought from private and governmental sources for a stable base of operating monies for the personnel and program support services for start-up and maintenance of quality programs. Plans call for the admission of a first class of 24 students in two years. Class size is projected to increase to between 60 and 96 students per year over the succeeding six years.

Local, regional, and state studies detailing unmet educational and medical needs of the past decade in Georgia gave impetus to the decision to implement the new school. The Bibb County Medical Society, City of Macon, and Bibb County Commissioners endorsed resolutions calling for the establishment of a medical school in Macon. In response to these efforts the Mercer Trustees in 1972 authorized a Medical Affairs Committee. Experienced medical educators completed a feasibility study in late 1972 and subsequently the Trustees agreed to sponsor a school, providing the fiscal resources were made available to it.

Funding a New School

Local, state, and federal sectors have committed funds for capital development. The Greater Macon Chamber of Commerce leads a $2 million drive for a structure to augment present science and library facilities at Mercer. Through the Department of Housing and Urban Development, Mercer has obtained 50 acres contiguous with its present Macon campus for Medical School and related activities. The State of Georgia has appropriated $5 million for a clinical teaching facility to the Bibb County Hospital Authority to be used for Medical School purposes. Release of these funds is contingent upon receipt of Federal funding for the school. The initial capital investment is $10.6 million. The first science teaching facility will need to be expanded in about four years when class size exceeds 50 students per class.

Two new buildings are planned. On the Mercer campus will be an expandable faculty-student science teaching complex with space for faculty offices, student and faculty laboratories, classrooms, medical library, and small animal care facilities. The initial structure of less than 40,000 square feet will need to be expanded on this site when student classes reach 60 per class. The second building will be the clinical teaching facility which will utilize the $5 million State appropriation. Plans have proceeded to architect's sketches for the building which will be located adjacent to the Medical Center of Central Georgia. The envisaged structure of nearly 75,000 square feet calls for space for parking, offices for clinical faculty, ambulatory patients, clinical student desk spaces, seminar rooms, multipurpose instructional laboratories, auditorium suitable for continuing education, and hospital library.

The present Medical School planning offices are in a refurbished apartment complex on the Mercer campus.

Mercer appointed Dr. Nat E. Smith, alumnus of the Medical College of Georgia, as Dean in November 1973.

Planning and Teaching Staffs

The planning staff includes a Coordinator for Basic Sciences, Medical Librarian, Assistant to the Dean for Administration, Director for Financial Development and five partially salaried clinical faculty who are full-time at the Medical Center of Central Georgia.

A volunteer clinical faculty of 116 area physicians

* Dr. Smith is Dean of the School of Medicine, Mercer University in Macon, Georgia 31207. He may be reached by phone at (912) 745-6811, ext. 350.

have been appointed clinical associates. This faculty is participating in planning and is essential for the conduct of future teaching with the salaried scientists and clinicans who will need be attracted to the effort. Faculty will eventually consist of full-time basic scientists, clinicians, and the volunteer faculty of clinical associates.

Most of the instruction for the first year students will be on the Mercer campus, second year students will move between Mercer and the Medical Center facilities, and the third and fourth year classes will study in the area hospitals, clinics, community health agencies, and in a series of ambulatory rural medical clinics to be supervised by faculty. Complementary to traditional science instruction, beginning students will study existing medical care resources and the roles of health care professionals. An M.D. advisor for each new student will participate to aid the student in becoming a contributing professional and in turn will receive stimuli from the student to pursue his own education in a continuing sense.

Clerkships will be conducted in each of the three general hospitals in Macon.

A portion of each student's time will be incorporated into the family medicine program each year.

A special feature for improved instruction in ambulatory medicine will be planned student responsibility between the model Family Medicine Practice Center and the rural medical clinics. Envisaged personnel include supervising faculty, residents, consultants, medical students, pharmacy students, nurses, and such physician assistants and technicians who may be attached to a clinic. In order to plan for feasibility and determination of locations, scope of services and educational programs that can prove practicable, the Georgia Regional Medical Program awarded a grant to Mercer that is presently at its mid-point.

Affiliation agreements have been signed with the Medical Center of Central Georgia, the Coliseum Park Hospital, and the Middle Georgia Hospital. Agreements will be sought for supplementary educational experiences with other hospitals in this region as program needs become more definitive.

The Medical Center of Central Georgia presently offers residency programs in family medicine, obstetrics and gynecology, and surgery. The School, in cooperation with the Center, will expand offerings in family medicine and proposes to institute residencies in pediatrics and internal medicine.

Plans for the Medical Library have accelerated since the appointment of a medical librarian who has developed plans for the personnel, space, usage, accumulations, storage, and retrieval of materials. More than 5,000 scientific volumes have been donated to Mercer in the past nine months.

Frequent questions have been posed about plans for health sciences curricula other than medicine. Our first need is to strengthen the sciences basic to medicine. No specific plans have been developed for other health science schools. Any curriculum plans will be evaluated in the light of the apparent needs in Georgia vis-a-vis the efforts of existent medical centers and schools in Georgia and the adequacy of support that can be assured for their implementation.

A national panel of distinguished medical educators, chaired by Dr. Charles Sprague, President, University of Texas Health Science Center at Dallas, has been formed as an advisory committee for review of present and assistance with long-range policies and plans. Formal admission policies and procedures have not been adopted but preference will be shown to qualified residents of Georgia. ■

ALBANY COURSE PLANNED FOR EMERGENCY MEDICAL PERSONNEL

A refresher course for emergency medical personnel, including registered nurses, licensed practical nurses, emergency medical technicians, rescue and civil defense workers will be given November 22-23, 1975 in Albany.

The Emergency Health Section of the Department of Human Resources has approved the course for 60 points credit towards recertification, a process required of emergency medical technicians every two years. Currently in Georgia some 4,500 people have completed the basic EMT course, but only about 1,800 are still actively employed in the field. To date, only two approved courses have been held in Georgia with only 400 EMTs being recertified.

Course director is C. B. Gillespie, M.D., of Albany, whose faculty of physicians will include: Willie Adams, Thomas A. Allen, O. B. Carter, George Chastain, W. M. Coleman, W. Carl Gordon, F. Dempsey Guillebeau, Thomas D. Johnson, and Phillip VanDeventer of Albany; Emile G. Abbott, Conyers; Robert F. Finegan, East Point; Lester M. Haddad, Savannah; Selwyn T. Hartley of College Park; Louis Levy of Columbus; and Charles B. Mosher of Atlanta.

For additional information contact Dr. Gillespie at 810 14th Avenue, Albany, Ga. 31701, (912) 435-1458.

A cornerstone of PA training is to develop respect for the physician, the health care team, and above all, the patient as an individual.

The Physician's Assistants Program at the Medical College of Georgia

JOHN R. PALMER, M.D., *Augusta**

The profession of physician's assistant (PA) is less than 10 years old, but it is one of the most rapidly growing health professions in the South. For example, as of July 1975, there were 301 certified PAs in Georgia alone, as compared to 108 only a year ago. Three PA training programs in the state have been approved by the AMA: those at the Medical College of Georgia, Emory University, and Georgia State University (specializing in the pediatric assistant).

The Medical College of Georgia includes a department of Physician's Assistants, which is based in the School of Allied Health Sciences.

Students enter the program at the third-year college level and are awarded a bachelor of science degree upon satisfactory completion of the program. Most of the students have a background in health care—nursing, military medical experience or allied health. The curriculum at MCG continues uninterruptedly for 24 months.

The average age of the present junior and senior student is 28. Women and minority group members comprise a significant part of the student body. Aside from the academic prerequisites for admission, the most important feature of the student is his or her personality type. Such characteristics are determined from lengthy interviews. Students are selected who are highly motivated for their roles as intermediate level health professionals and who demonstrate outgoing personalities.

The "Essentials for a Program to Train Primary Care Physician's Assistants," promulgated by the American Medical Association's Council on Education, have been met. The program received full approval in March 1975. The program is also approved by the Georgia State Composite Board of Medical Examiners. Graduates of the program are eligible to take the examination for primary care physician's assistants administered by the National Board of Medical Examiners.

* Chairman and Program Director for the Physician's Assistants Program at the Medical College of Georgia, Augusta, Ga. 30902.

Three-Phase Curriculum

The student learns principles of biochemistry, anatomy, physiology, microbiology, and pharmacology in mid-level courses taught by the respective basic science faculties of the medical school. During this initial nine-month phase of the curriculum the student also completes courses in the techniques of physical examination, human growth and development, and data recording.

The second phase of the curriculum, lasting from the summer quarter of the junior year through spring quarter of the senior year, involves clinical rotations and electives in the broad fields of medicine, surgery, pediatrics, family practice, obstetrics and gynecology, and mental health.

The resources in the Augusta area which provide these educational experiences are Talmadge Memorial Hospital, Ft. Gordon Army Hospital and Georgia Regional Hospital. In these institutions students participate in inpatient and outpatient care, as well as lectures and seminars.

Insofar as possible, physician's assistant faculty instructors are assigned to clinical departments to serve as role models for the students. More instructors in this capacity are needed and are being recruited. In a health care profession as new as this, educating teachers (PAs) to teach has been a prime consideration. The lack of sufficient role models has been and continues to be a problem. In addition to the primary learning sites, electives are available in a variety of community health care institutions throughout the state.

The third phase of the curriculum is a preceptorship under a physician in practice. This enables the student to encounter the "real" world and provides a

probationary period which may lead to future employment by the physician.

Training Goals

Program objectives will have been attained if the graduate is able to collect reliable clinical data through medical history, physical examination, and pertinent laboratory examinations. The physician's assistant will be able to record these data in a form and employing terminology acceptable to the physician. The record will state the problems but is not expected in all cases to define the problem completely. The physician's assistant will be able to state that an organ system is normal, abnormal or equivocal. The PA relies upon the physician to verify and further refine the data and to provide the decision-making once the physician has arrived at a diagnosis. It is expected that over varying lengths of time the physician will upgrade his assistant to a point at which, when findings are clearcut and the physician's routine management of a specific minor disease entity is well understood, the physician would simply be informed that a particular case had been handled in the prescribed manner.

The Physician's Assistant learns to accomplish a great many practical tasks the physician will find useful, such as completing forms upon which patient data are recorded, maintaining office supplies, arranging for patient consultation and transportation, as well as educating the patient as to the patient's responsibility in carrying out the physician's plan of management. Equally important, he or she learns communication skills which the physician will find helpful.

The program spares no effort in defining the limitations his education imposes upon the physician's assistant. Through limited exposure to the vast vistas of medical knowledge and practice, the student comes to appreciate what physicians must be able to cope with in order to assume responsibility for their sick and injured patients.

The physician's assistant's education includes respect not only for the physician but for others of the health care team as well. Above all, he learns to respect the patient as an individual—an individual with needs for restoration to as near a state of good health as possible.

It has been stated on good authority that the basic attitudes of students of all kinds toward the medical college do not change. We strive to reinforce the worthwhile attitudes of the vast majority of students, exercising special efforts to assure the development of acceptable attitudes and behavior.

The physician has the responsibility of assessing his PA's needs and, through a constant process of continuing education, to shape his assistant into a team member to his own satisfaction. The contributions of physician's assistants to health care will depend largely upon employing physicians, and the future of this new health profession will be observed with care by all involved. ■

HEART DAMAGE SEEN IN MALNOURISHED MONKEYS

Juvenile monkeys malnourished by a very low protein diet showed heart damage and reduced heart size in a study at Emory's Yerkes Regional Primate Research Center.

Dr. Sohan L. Manocha, chief of experimental nutrition studies at the Yerkes Center—a Division of Emory's Woodruff Medical Center—said that pilot studies with squirrel monkeys indicate a protein-deficient diet can result in destructive metabolism in the heart muscle.

He plans to expand his studies to see what effect protein malnutrition in female monkeys will have on the hearts and cardiovascular systems of their infants. His research is supported by a new grant of $7,000 from the Georgia Heart Association.

"Our pilot studies on the hearts of young juvenile squirrel monkeys, malnourished over a 15-week period with a diet containing two per cent protein, revealed that the heart weight decreased in the malnourished animals by about 12 per cent as compared to the healthy monkeys," Dr. Manocha said.

"The hearts of malnourished animals showed a flabby appearance and the tissue studies showed gross abnormalities of the muscle fibers. From the data collected so far, indications of increased catabolic (destructive) metabolism in the cardiac muscle are evident.

"The activity of enzymes belonging to important metabolic pathways is greatly affected and is being studied. The effects of maternal malnutrition during the critical stages of the heart's development in the fetus could be more profound."

Dr. Manocha said that monkey fetuses taken from malnourished mothers maintained at a diet containing 8 per cent protein calories will be studied for heart damage at different stages of gestation.

The research is expected to give important clues to what is happening to children of malnourished human mothers throughout the world, especially in underdeveloped countries where famines and protein malnutrition are common.

The author outlines the steps needed to set up a residency program and describes how his hospital in Rome plans to conduct its training.

Family Practice Residency Programs in a Community Hospital

M. C. ADAIR, M.D., *Rome**

SINCE THE FAMOUS Millis Report rendered in 1966 which addressed itself to the need of people in the United States in health care, there has been increased interest in the training of family physicians whose thrust is continuous and comprehensive primary health care management for families. This report also indicated that there was a need to train physicians in ambulatory health care since most of the pre-graduate and post-graduate training of physicians was in horizontal care based chiefly in hospitals. The unique element therefore in a family practice residency training program is to be a model ambulatory health care center. Residents are taught to manage patients in a manner resembling that which will be expected once they enter practice in a community.

It is a well known fact that there is now a disproportionate number of specialists in this country and that there are not nearly enough family physicians. Accordingly, new training programs are springing up all over the country and these, to a great extent, are based in community hospitals.

Ideal Situation

Ideally, a community hospital which contemplates a family practice residency training program should contain 200 or more beds and should have basic facilities such as operating rooms, emergency rooms, delivery rooms, radiology, pathology, and laboratory facilities, a well organized staff, and adequate representation in the major disciplines including internal medicine, surgery, obstetrics, gynecology, psychiatry and pediatrics.

The hospital must be approved by the Joint Commission on Accreditation. Surveys should be made confirming an acute shortage of family physicians in both the region of the community hospital and the surrounding satellite counties within the trade area. There should be an interest in this type of program by the county commissioners, the hospital governing board, the hospital professional staff, and the family physicians in the area.

The first step in the organization of a family practice residency training is to have a planning committee. With the help of the hospital director and other interested people, an effort is made to recruit a program director. Ideally this is an experienced family physician, but it could be an internist or any practitioner who is acquainted with family practice problems and has experience in rendering primary health care. At this point it is also wise to identify funding sources for the training as a whole because it is well recognized that only approximately 50 per cent of the costs involved are generated by fees charged for service.

After a director is hired, it is important that he identify all of the resources of the hospital and community that could be utilized in the training of family physicians. When these resources are located, the director must put together an application to the AMA Residency Review Committee for Family Practice. When this is prepared, a consultation is generally sought from the American Academy of Family Physicians and a direct consultation is made from this organization by someone experienced in graduate medical education. Following this, the application is forwarded to the AMA Committee on Education and in the next 18 weeks a site visit is made by a member and the application is reviewed by the Residency Review Committee. This Committee forwards its findings to a Liaison Committee on graduate medical education and, hopefully, within seven to nine months after original application there is approval. Once the program is approved an application for participation in the National Intern and Resident Matching Program is prepared and hopefully some newly graduated physicians will become available for the training in family medicine.

* Dr. Adair is himself a family physician and director of medical education at Floyd Hospital in Rome, Ga. 30161. He is a member of the Subcommittee on Continuing Medical Education of the MAG Education Committee and chairman of the Committee on Access to Health Care.

Experience at Floyd Hospital

Floyd Hospital in Rome, Georgia, is a community hospital of 300 beds. It possesses the resources already outlined previously. The professional staff feels that this training program would benefit both the hospital and the graduate physician because of the wealth of clinical material and the services available. The first year of the program is structured as a rotating 0 or a rotating 9 internship. There will be exposure to surgery, internal medicine, psychiatry, pediatrics, ob-gyn, and community medicine. The first year level resident will also begin to see patients two afternoons a week in the ambulatory health care center. The resident will thus begin to follow some families for the three years it is anticipated that he will be in training. Work will be assigned this year consistent with the resident's level of expertise and will be closely followed by the program director and the staff of training physicians. At the second year level, those residents who plan additional experience in obstetrics will be allowed to continue in this discipline and will also do more complicated gynecology. There will be two months in the emergency room under the direction of full time emergency room physicians. There will be additional internal medicine which will include intensive care and coronary care experience. There will be some training in orthopedics, ear, nose, and throat, and ophthalmology useful to a family physician.

In the third year it is hoped that some preceptors can be located who will make their offices available for two months training of family practice residents so that these people will be able to see what the real practice world of medicine is like. Electives will be available. These will include more training in gynecology and additional exposure to the subspecialties such as cardiology, gastroenterology, dermatology, radiology, pathology, and so on.

During the three year period the residents will be taught the business side of medicine and the problems that go with it, and will be required to practice in a cooperative group, in a mock legal partnership, and in a mock professional association. It is realized that no experience within the hospital setting can be identical to family practice in the community but the objective will be to come as close to this experience as is possible.

It is estimated that the cost of a family practice residency program is roughly $30,000 per resident per annum. A model family practice unit has to be established and operated. The remainder of the training is within the community hospital or in other local medical resources. Preceptorships qualified in family physician's offices will be arranged. Floyd Hospital plans to reach an ultimate goal of 12 residents, four at each year level. The family practice center will generate some income and it is expected that there will be some federal or state funding. Active affiliation with the Medical College of Georgia is being sought and the Director already has an appointment on the faculty of the Medical College. It is expected that there will be an active professor visiting teaching faculty and the local specialists will assist in the teaching in their areas of training. There will also be guest speakers.

Return on Investment

When the residency is completed it is hoped, based on statistical surveys, that approximately 75 per cent of the residents will remain in the area thereby relieving to some extent the shortage of family physicians. This is an effort to fill what is considered to be a need in the health care system in most rural and urban areas. The training should also be adequate to qualify a resident to pass the Boards in Family Practice.

The development of family practice residencies is a new and exciting chapter in the history of medicine. It is an attempt to answer the problem and the question, "Where can I find a physician?" Family physicians are taught to regard the total patient rather than any one segment of that total patient. Family physicians, in their offices, should be able to render approximately 80 per cent of the care necessary for their patients. They should also know when to call in expert help and should also know what resources are available both in the area and in distant facilities. Family physicians must develop an interest in continuing medical education in an effort to keep their skills sharpened because of the dynamic changes inherent in the practice of medicine. ■

editorials
editorials
editorials

Even Dogs Do It!

CONTINUING EDUCATION is neither new nor limited to medicine. Earlier this year I learned from a lawyer friend that there are active continuing legal education programs. (I was afraid to ask what the lawyers are being taught.) My pastor tells me that he attends continuing religious education programs. My mother has returned to school to continue her education, only partly because community colleges in Virginia are free for senior citizens. Even my dog, now age ten, learned a new trick this year from my children. (When asked whether he would rather go to the University of Georgia or be dead, he rolls over on his back. As a matter of fact, he responds in the same way to Georgia Tech, Alabama and even the University of Virginia!)

No less a teacher than William Osler was a strong advocate for continuing medical education. Dr. Edward C. Rosenow, Jr., executive director of the American College of Physicians, writing in the August 1975 issue of the American College of Physicians Bulletin, quotes Sir William's paper, "The Importance of Postgraduate Study." "There are two great types of practitioners—the routinist and the rationalist—neither common in the pure form. The mind, like the body, falls only too easily into the rut of oft repeated experience . . . only one thing will pull him out of this rut—a prolonged course of additional study. In reality they suffer from the all prevailing vice of intellectual idleness."

Stamping Out Intellectual Idleness

The Medical Association of Georgia, through its Committee on Education, intends to help stamp out intellectual idleness in its members, indeed, in all physicians in Georgia. This issue of the **Journal** describes some of the educational activities with which the Association is concerned. While the Committee is concentrating on continuing medical education in community hospitals, it is also incubating other educational schemes, e.g., an information system for small hospitals and a complex system for health education of the public. A patient care evaluation program is already in the process of being hatched by Austin Flint, M.D. of Canton.

The Education Committee has one great thing going for it. Almost all doctors like to learn new things. Education cannot yet compete with water, food, sex and shelter as a basic human need, but it is not too far down the list.

The Education Committee does not agree with the old saying, "You can't teach an old dog a new trick." Certainly you can. He just needs to be interested and motivated. And that is exactly what we hope to do.

Nicholas E. Davies, M.D.
Chairman, Committee on Education
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Radiation and Thyroid Cancer

NEW CONCERNS

DONALD W. DEBRA, JR., M.D., *Decatur**

SEVERAL DECADES AGO it was a common medical practice to administer X-irradiation to children, and less frequently, adults, for benign disorders of the head and neck area. These included enlarged tonsils and adenoids, enlarged thymus of infancy, facial acne, cervical adenitis, hemangiomata, thyroglossal duct cysts, Eustachian tube disease, dermatitis, pertussis, and fungus infections.

Twenty-five years ago Duffy and Fitzgerald postulated a possible relationship between childhood thyroid carcinoma and a history of thymic irradiation during infancy.[1] A number of subsequent studies have established that this observation is valid.[2–6] In addition, Hempelmann's studies confirmed that the prevalence of benign thyroid tumors was also increased. Publications of other investigators have shown that external irradiation to other areas of the head and neck is also associated with an increased risk of developing childhood thyroid carcinoma. Most of these were papillary carcinomas, but all histological types were represented. One study revealed that in 277 children with thyroid carcinoma, 221 (80 per cent) had a history of previous X-ray therapy which would have included the thyroid gland within the portal of administration.[7] Most investigations showed that half to three-quarters of children with thyroid cancer gave such a history. The radiation, usually between 300 and 600 rads, was given almost always within the first five years of life.

Data on the effects of external irradiation to the thyroid glands of adults are sparse. The investigations of the Atomic Bomb Casualty Commission on occurrences of thyroid cancer in irradiated survivors of Hiroshima and Nagasaki were suggestive of a causal relationship, though the results were not conclusive.[8, 9]

Over the past two years there has been publication of an impressive body of evidence that the risk of developing thyroid cancer as a result of childhood irradiation may extend later in to life than had previously been recognized. This work has come largely from the Thyroid Study Unit of the University of Chicago. DeGroot and Paloyan, writing in *JAMA* in 1973, found that 40 per cent of a group of thyroid cancer patients had received prior neck X-irradiation an average of 20 years earlier. They stressed the difficulty of obtaining this history, stating that often the patient himself was unaware of it and only the parents could provide it.[10]

Early this year Dr. DeGroot and his associates published an extension of their earlier findings. Some 100 adult patients were seen solely because of a known history of prior head and/or neck irradiation. Any with a known thyroid abnormality (e.g.: palpable nodule) were not included in the study. Operation was recommended to patients with discrete nodules, those with glands more than twice normal size, or abnormal consistency of the thyroid gland unexplainable by a benign condition (e.g.: Hashimoto's Disease). Surgery was recommended to 18 patients and 15 accepted. Seven of these had carcinomas, 5 of which appeared invasive microscopically. Two of seven patients irradiated in both the tonsil and adenoid areas had carcinoma, suggesting that risk may be dose-related. The average number of

* Dr. DeBra is an endocrinologist who is in practice at 2712 North Decatur Road, Decatur, Ga. 30033.

years since irradiation was 24.4.[11]

The Chicago group recommends placing all patients with a significant irradiation history on thyroid replacement, for the purpose of suppressing serum thyrotropin (TSH) levels to the subnormal range.[10] TSH has been shown to play a role in the development of experimental thyroid carcinoma in irradiated animals, but its role in the development of human neoplasia is unknown. Because this is an innocuous measure, it seems prudent. An additional potential benefit pointed out by one of Dr. DeGroot's associates is that when TSH is suppressed, normal thyroid tissue atrophies, and then some small nodules, previously undetected by scan or palpation, become palpable.[12]

Because X-irradiation for benign lesions is no longer performed, in time this risk factor for thyroid cancer will fade from the general population. For the present, however, a history of childhood irradiation to the head and neck areas exists in a considerable number of young adults in this country. The University of Chicago group estimated that in the Chicago area alone there were approximately 71,000 such individuals. One institution in the Chicago area delved into its records and found 5,000 patients who had been thus treated.[10]

Based on this new knowledge, certain recommendations can be made:

1. It should be the policy in all institutions and practices which administered head and neck irradiation to identify from its records those individuals so treated and to seek them out and advise them to have a thyroid evaluation.

2. Physicians engaged in the general care of adults should incorporate questioning about head and neck irradiation into their history-taking. Further, they should direct the patient to inquire of his parents or guardian if a negative history is obtained. Records regarding the type of radiation given and dosimetry should be sought.

3. Irradiated patients should have a thorough examination, including careful palpation of the thyroid and adjacent node-bearing areas. A chest film should be made and a thyroid scan performed. Surgery should be recommended to all who have the findings mentioned in the text above. For those who do not, it is recommended that they be placed on a suppressive dose of thyroid hormone (sodium L-thyroxine 0.15 to 0.25 mg/day) and that serum TSH levels be measured to ascertain suppression. The patient probably should have a careful examination of his thyroid gland performed annually throughout his life. The occurrence of any nodules should be grounds for surgery, unless a satisfactory and certain alternative explanation can be found. ■

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heart page
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Cigarette Smoking and Premature Cardiovascular Disease

W. MICHAEL BAILEY, M.D., *Macon**

PREMATURE CARDIOVASCULAR DISEASE in the western world today is occurring in epidemic proportions for many known and many unknown reasons. This brief résumé will cover one of the most clearly defined but yet most poorly understood factors in the development of premature coronary and generalized atherosclerosis: namely, cigarette smoking.

It has been felt by the medical profession intuitively for many years that cigarette smoking is associated with an increased risk of developing coronary artery disease. However, only in the past five to 10 years has the carefully collected epidemiologic data from Framingham, Massachusetts,[1] Goeteborg, Sweden,[2] and others been available for careful scrutiny by the medical community. It becomes immediately clear from a review of that data that cigarette smoking is truly hazardous to the user's health.

A number of shocking statistics should be presented to clarify the generalizations mentioned above. The background risk for the development of coronary artery disease in an otherwise healthy Western European or American non-smoking, thin male without hypertension, diabetes, elevated lipids, and with a totally negative family tree and a type B personality is significantly higher than an equally matched non-Western patient. Adding to this high background risk would be a two- to three-fold increase in the likelihood of developing coronary heart disease in a smoker using 15 to 25 cigarettes per day.[3] More alarming than that factor is the four- to six-fold increase in the background risk in a two to three pack per day smoker.

Additionally well known but less publicized data point strongly to the strikingly increased incidence of atherosclerotic peripheral vascular disease and abdominal aortic aneurysm (in decreasing order of incidence) secondary to cigarette smoking as well.[3]

Multiple Etiologies

The causes of this accelerated atherosclerosis in smokers are totally unsettled at this time. However, multiple laboratory and clinical studies point to probable important multiple etiologies for this disease. Nicotine itself causes a chronically increased heart rate, a chronically increased cardiac work, and a chronic myocardial irritability. The data also suggest an increased platelet adhesiveness intra-arterially secondary to nicotine.[3] Carbon monoxide is probably a more important etiologic factor in accelerated atherogenesis. Clear-cut subendothelial edema of small arterioles (and the vasavasorum of larger arteries) has been seen predictably in laboratory animals exposed to carbon monoxide chronically.[4] Acute effects pathologically are seen also, but we will not deal with those at this time.

From these startling facts mentioned above, it seems clear that, logically, ciga-

* Dr. Bailey's cardiology and internal medicine practice is with Internal Medicine Associates, 724 Hemlock St., Macon, Georgia 31201. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

rette smoking should never be begun by anyone. For those presently smoking, however, there is some heartening news. Rose has stated in 1973 in his concise review of the cigarette smoking problem that discontinuing cigarettes for a period of five to 10 years causes a gradual normalization of coronary risks that are essentially equal to a controlled non-smoking population at the end of that five to 10 year period.[3] This feature of reversibility is interesting and may indeed be related in part to normalization or stabilization of previously swollen arteriolar edema caused by carbon monoxide.

In summary, it is clear that the ultimate answer to coronary artery disease and arterosclerotic peripheral vascular disease somehow lies in the prevention of those risk factors before the disease even begins. Clearly there is a great push now to control hypertension, recognize diabetes, detect those with lipid abnormalities, as well as to stress the cessation of cigarette smoking. However, all in all, we can clearly see that further investigation into the problems of atherogenesis on a laboratory level and on an epidemiologic level will need to continue so that the disease can truly be prevented rather than treated symptomatically. ■

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PHYSICIAN STRIKES BACK AT A 'CHEAP SHOT'

(Ed. Note: The following Letter to the Editor was printed in the August 28, 1975 issue of The Atlanta Constitution *in response to an editorial cartoon which appeared a few days earlier. It is reprinted with permission of the author, William M. Moore, Jr., M.D. of Atlanta, and the newspaper.)*

Ouch! A cheap shot hurts even if you expect it. In the list of past coverage by your paper of medical-economic-social problems, Baldy's cartoon appearing on Aug. 22, could have been anticipated, but this in no way takes away from the fact that it represents a completely unfair and irrational reaction to the facts at hand.

I would like to propose a hypothetical situation for your consideration. Let's just suppose for a moment that the newspapers constituted the only proper means of bringing the news to the people. There might be other ways of getting news such as listening to the Cuban or Russian shortwave broadcasts but the only really "honest" news could be obtained only through the newspapers. Secondly, let's presume that the people have a "right" to good and honest news and thirdly, let's presume that the State comes along with a program to provide that news to the poor people who cannot afford the price of the paper—let's call it Publicaid. Now, in order for the *Atlanta Constitution* to be eligible to administer Publicaid, it would have to agree to be bound by a Policy Manual that it had no part in writing. Furthermore, it would have to agree to be bound by any further changes in that Policy Manual that were made, again without having any formal input into how or what circumstances or to what degree those changes were made. Included in this Policy Manual would be a number of items that would limit the topics of news that the *Constitution* could report and the depth of detail into which the reporting could go. In addition, no matter how newsworthy an item might be, it could only be reported once in a month's time unless written permission was obtained in advance from a clerk in the Publicaid office.

Then, on top of these requirements, let's suppose that the *Constitution* were told that it would be illegal for them to sell this newspaper to any person qualified under the Publicaid program at the market price even if the poor person had by work or good luck found himself with the funds to make him able to purchase the paper. In such an instance, it would be the obligation of the *Constitution* to collect the money from the poor person and then refund it to the State Publicaid Office, and the *Constitution* would be reimbursed at the schedule of payments determined not by the State but by the Federal Government on the basis of the cost of doing business from several years past.

To put the icing on the cake, let's suppose that the State then said, "Since we don't know how many people really want this paper and have no accurate way of predicting this, we will only make payments on the assigned basis within the limits of our appropriation. However, we will expect you to continue to provide the newspaper to these people and when we get into a financial bind, we will prorate the resources that we have and pay you the prorated share of available funds, whatever that may be."

I really wonder what the reaction of the *Constitution* and other newspapers would be to being presented with such a situation. I am inclined to think that they would not lie down and roll over and say to the State, "Do as you please."

William M. Moore, Jr., M.D.

Tax Exemptions for Hospitals

H. MARVIN MERCER, III, *Atlanta**

THE SUPREME COURT of the United States has recently decided to hear an appeal in a case which has raised many doubts regarding the exemption that most hospitals enjoy from federal income taxation. The final ruling by that court may radically alter the present state of the law. This article will trace the past development of this area and analyze the present position of hospitals vis à vis the Internal Revenue Code.

Federal tax law provides that organizations listed in Section 501(c) are exempt from taxation. Though they are not specifically included, hospitals have been exempted as charitable organizations under Section 501(c)(3). To qualify, a hospital must comply with the following requirements:

1. It must be organized and operated exclusively for charitable purposes;
2. No revenues of the hospital may benefit any private shareholder or individual; and
3. The hospital must not devote a substantial part of its activities towards influencing legislation nor engage in any political campaign.[1]

To be regarded as operated exclusively for charitable purposes, the hospital must engage primarily in activities which accomplish such purpose, and only an insubstantial portion of its activities may be in furtherance of non-charitable purposes.[2] It must also serve a public rather than a private interest.[3]

If the above conditions are met, and if the hospital is organized in the United States, and if all donations are used within the United States, donations to the hospital will constitute charitable contributions. As such, these donations are deductible from income on the individual income tax returns of the donors.[4] The deductibility of gifts made to hospitals is a very important reason for being classified as a Section 501(c)(3) "charity."

Requirements Named in 1956

In a 1956 revenue ruling, the Internal Revenue Service enunciated the requirements that a hospital must meet to constitute a public charitable organization. First, it had to be "organized as a non-profit charitable organization for the purpose of operating a hospital for the care of the sick." Secondly, *to the extent of its financial ability,* the hospital must provide services free of charge to indigents. At the same time, it was expected to charge those able to pay. A relatively low charity record was acceptable "in the absence of charitable demands of the community." Charity could be rendered by providing services at reduced rates. The production of profits and their use for improvements to hospital facilities were also considered proper. However, mere acquiescence by the hospital in the failure by some patients

* Prepared at the request of The Medical Association of Georgia. Mr. Mercer is a third year student at the University of North Carolina at Chapel Hill School of Law, and is a summer associate with Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, C & S National Bank Building, Atlanta, Ga. 30303.

to pay for services rendered was insufficient charitable activity, when the hospital operated with the expectation of full payment by all patients.

Other requirements were that the hospital must not restrict the use of its facilities to a particular group of physicians and that its net earnings must not benefit any individual. All of these requirements were considered necessary by the Internal Revenue Service, if the hospital were to be classified as charitable under Section 501(c)(3) of the Internal Revenue Code, which, according to the IRS, "contemplate[d] an implied public trust constituted for some public benefit."[5]

Prior to 1956, the IRS had contended that status as a charitable organization should be denied even when a hospital charged financially solvent patients. The U. S. Fifth Circuit Court of Appeals and the Tax Court both rejected this argument.[6]

Clearly, the cost of patient care cannot be met today through governmental and private donations. To require hospitals to furnish all care without charge would render impossible the charitable services they presently perform. However, the Tax Court did note, over 10 years before the 1956 Revenue Ruling, that status as a charitable institution required admission and treatment to those unable to pay.[7]

In a 1958 decision applying the 1956 Revenue Ruling, the Tax Court held that the Olney Foundation, Inc. was exempt from taxation because it was both organized and operated for charitable purposes. The court found that this hospital had not denied treatment to any patient because of indigency and that no investigation was made regarding his ability to pay upon application for admission.[8]

Later, in 1966, the Tax Court cited the 1956 Revenue Ruling to deny a tax exemption under Section 501(c)(3).[9] Ruling that the mere operation of a hospital did not *ipso facto* qualify as charitable activity, the court based its decision that the hospital was not operated exclusively for charitable purposes upon several factors. Included among them was the failure of the hospital to ever hold itself out to the public as a charitable institution, and the rendering of free care on a *de minimis* level—less than one per cent of paid care. Since the charitable activities were practically non-existent, and the hospital was operated largely to the financial benefit of the founding doctors, the court denied the exemption.

IRS Takes Dramatic Shift

In 1969, there was a dramatic shift in the position of the Internal Revenue Service. Many hospital representatives had claimed that they should be classified in the same manner as educational and scientific organizations; that is, as charitable activities regardless of their philanthropic performance. In that year, an IRS ruling allowed an exemption where the articles of organization of a hospital limited the organization's purposes to charitable areas and where the hospital operated a full-time emergency room which was available to all requiring emergency care.[10] If these criteria were met, a hospital was still viewed as charitable, although it ordinarily limited its admissions to financially solvent patients or Medicare recipients and referred others to community hospitals that performed indigent services. The IRS had finally agreed that the promotion of health was *per se* a charitable purpose and deemed beneficial for the entire community, even if certain segments of the community, such as indigents, were excluded, provided these excluded segments were sufficiently small. By operating an emergency room open to all, by providing health services to those able to pay, and by complying with certain other open staff requirements, a hospital was considered as promoting the health of a class of persons that was "broad enough to benefit the community."[11]

In 1974, a Kentucky welfare organization sought to prevent the use of the 1969 ruling in qualifying hospitals as charities. It contended that the new ruling was contrary to Congressional intent and relevant judicial, legislative, and administrative history on the matter. The Court of Appeals for the District of Columbia Circuit rejected their contentions and upheld the 1969 ruling.[12]

According to the court, the word "charitable," as used in the Treasury Regulations, permitted a definition far broader than merely aid to indigent members of society. The Court stated that while hospitals were once "almshouses supported by philanthropy," the soaring costs of medical care and the growing use of hospitals by all segments of society had radically changed the nature of the institution. Furthermore, the growth of Medicare and Medicaid had eliminated much of the populace who required free hospitalization.

The court also noted that a hospital still must provide services to indigents in the form of free emergency care. This requirement was without qualification. Under the 1956 ruling, which required the rendering of free services only to the extent of a hospital's financial ability, a hospital operating at a deficit had no obligation to the poor. Finally, the 1969 ruling required the acceptance of Medicare and Medicaid patients to obtain exempt status.

However, a subsequent opinion by the U. S. Sixth Circuit Court of Appeals[13] questioned whether mere compliance with the 1969 Revenue Ruling would be sufficient to obtain a tax exemption. Here, the court denied an exemption for several reasons. Among these was that the doctors who operated the hospital received considerable private benefit. This factor was in violation of both the 1956 and the 1969 ruling. However, the Court refused to select any single factor as controlling. The other factors included the failure of the hospital to hold itself out to the public as a charitable institution, the lack of public donations, and the omission by the hospital to establish a specific plan or policy for the treatment of charity patients. Only after other funds were exhausted were patients treated as charitable cases.

The opinion does not indicate whether there was an emergency room service for all persons regardless of financial status, but the type of psychiatric treatment exclusively rendered by the hospital implied that an emergency facility was not necessary for medical purposes. Thus, it is not clear that the failure to establish a specific plan or policy for the treatment of charity patients would alone constitute grounds for a denial of a Section 501(c)(3) exemption. One should note that the court did not rule on the validity of the 1969 ruling but assumed that it was valid. Yet this ruling does not require any specific plan beyond the furnishing of emergency service to indigents, a service probably not required for medical reasons in this instance.

It is not entirely clear to what extent free medical services must be provided or how important the provisions of free services are as a single factor in determining exemptions under Section 501(c)(3). Certainly, other tests such as prohibition of private benefit from the revenues of the hospital must be met. Consequently, as the possibility of private utilization becomes increasingly suspicious, the more stringently the indigent services may be scrutinized to determine whether the hospital serves a public function. As to what extent free hospitalization must be provided, free emergency care is a minimum. When this is not required by the specialized medical pursuits of the hospital, some specific plan for poor relief must be substituted.

It is also not clear at the present time whether a specific plan other than, and in addition to, an emergency ward is required. There may be a further obligation for the hospital to present itself as a charitable organization for purposes of receiving donations and advertising the free services provided.

The United States Supreme Court has agreed to review the lower court's decision in the Kentucky welfare organization case.[14] A decision by the Supreme Court will probably enunciate more definite guidelines and serve to clarify what is now a somewhat confused area of tax law. ■

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C. DANIEL CABANISS, NEW PRESIDENT OF HEART ASSOCIATION

C. Daniel Cabaniss, M.D., of Columbus, director of medical education at The Medical Center in Columbus and associate professor of medicine (cardiology) at Emory University in Atlanta, is new president of the Georgia Heart Association. He succeeds Robert G. Ellison, M.D., of the Medical College of Georgia.

Joseph A. Wilber, M.D., of Atlanta, supervisor of the adult health section of the Georgia Department of Human Resources, has been chosen president-elect of GHA. Macon businessman Myer O. Sigal is chairman of the board.

The installation of new officers and members of the board of directors took place September 12 during the GHA's 27th Annual Meeting and Scientific Sessions at the Royal Coach Motor Hotel in Atlanta.

Other officers are Nanette K. Wenger, M.D., and Joe T. LaBoon, both of Atlanta, vice presidents; Wilson P. Mason of Augusta, secretary; and Claude Williams, Jr., of Athens, treasurer.

The following were elected to three-year terms on the board of directors: Robert P. Cunningham, M.D., John Gill, Jr., M.D., and Rev. Edward R. Davie, all of Atlanta; Dorothy Brinsfield, M.D., Jim Cherry and Quinton C. Vrooman, Jr., all of Decatur; Malcolm I. Page, M.D., of Augusta; Mrs. Melba Nettles of Savannah; Mrs. Huldah C. Mingledorff of Sylvania; and Jack E. Birge, M.D., of Carrollton.

President Cabaniss is a graduate of the University of Georgia and the Medical College of Georgia, interned at the Medical College of Virginia and was an assistant resident in medicine at Grady Memorial Hospital in Atlanta. Also at Grady, he served fellowships in neurology and cardiology.

Before moving to Columbus in 1970, he was director of the coronary care unit of Georgia Baptist Hospital in Atlanta.

Dr. Wilber, in addition to his duties with DHR, is in private practice of internal medicine, medical director and vice president of Georgia International Life Insurance Company, and clinical associate professor of medicine at Emory University.

He studied at Harvard Medical School and served an internship and residency at Boston City Hospital, Boston, Mass. He was a residency and research fellow at Grady Memorial Hospital in Atlanta and a U.S. Public Health Service research fellow in hypertension at Oxford University, Oxford, England.



Incoming GHA President C. Daniel Cabaniss, M.D. of Columbus (L) is congratulated by his predecessor Robert G. Ellison, M.D. of Augusta.

The Georgia Heart Association is the only organization in the state devoted exclusively to the fight against all diseases of the heart and blood vessels.

GHA has on-going programs in high blood pressure detection and control and cardiopulmonary resuscitation (CPR) training, a statewide system of heart clinics for indigent patients, and continuing support for heart research in Georgia and other parts of the nation.

I've told this before . . . .

(Ed. note: Author J. G. McDaniel, M.D. describes the time he was invited to join an "exclusive" country club with rather unusual requirements, facilities and activities. Others wishing to contribute stories to this feature page, should contact the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

The Myrtlewood Country Club

RECENTLY A FRIEND by the name of Kelly Mosley invited W. E. (Muddy) Waters and me to go with him to see his tree farm which is in Western Alabama near the little town of Myrtlewood.

It seems that Kelly had inherited some of this land years ago and had added to it from time to time. It had grown up in all sorts of trees and underbrush. Over the years the timber had been cut occasionally but no thought was ever given to the future.

Kelly is in the process of changing all that and with the cooperation of the county agent, the foresters and the soil conservation officers, he is gradually making it into a model of scientific tree farming.

It was a great joy to ride through the woods and see beautiful tall growing pines, poplars and sycamores, to see the undergrowth thinned by controlled burning and poisonous sprays, to be startled by white-tailed deer scampering to safety. We enjoyed seeing other game and fishing in the lakes in front of his lodge.

On the second morning I accompanied Kelly on a visit to the only general store in town. Out behind was a white man and a black man standing beside a tractor. They were digging a ditch. The black man was doing most of the work and the white man all the talking. It turned out that Mr. Fred Adams owned the store, but leased it to the people operating it. He owned and his wife operated the laundromat. We talked while Kelly went into the store. When he learned that I was a retired M.D., he said that I was just the man that they needed to join their country club, if I could qualify.

He noted my hesitancy and insisted that I look at the Myrtlewood Country Club before rejecting membership. I explained that I did not have time to visit it, especially since Kelly would be back any minute now. Then he said, "Well, you are looking at it. There it is right there."

It was a building about 40 feet by 20 feet enclosed with heavy plastic. In it were four tables, around each table were four nondescript but comfortable chairs. At each end was a bench that would accommodate five or six people. On every table was a set of dominoes. There were doors at each end, also an air conditioner and heating unit.

It seems that the Myrtlewood Country Club was founded in 1962. Fred's wife had left him that year, I do not know for what reason, but Fred said "for good and sufficient reasons." Anyway, Fred and several of his friends would gather at his home about 2 o'clock and play dominoes. Then in 1964, he up and married again to a charming lady by the name of Bertha. It wasn't long before this new wife spoke to Fred, as only a wife can do, "no more men cluttering up her living room every afternoon." And so they moved over to a widower's house. Then he got married . . . and that was that!

They polled every member and, to a man, all said that their wives or daughters were positive, "no playing dominoes" in their homes every afternoon.

And that's when the Myrtlewood Country Club was built. Among the group were "jacks of all trades." They put up two by fours on the back of Fred's property, covered it with heavy plastic, found some discarded doors, chairs and

tables, got traded-in heaters, air conditioners and it's as comfortable as you please.

They meet every weekday afternoon at 2 o'clock and play dominoes until supper time. Then on Friday night they play from 8 p.m. on. A member is expelled if he bets even a penny or a nickel. No alcohol allowed. Smoking, tobacco chewing and whittling are permissible. I saw one man whittling on a cedar stick and chewing tobacco. I asked him what he was making, he spat and said, "nothing," but as he watched the game, thinking of what he was going to play next, he would slice off a few slivers with a razor sharp knife, then lay his wood and open knife in his lap and play when his turn came.

I asked Fred how they financed the lights, heat and repairs. He pointed to a short wide tin can nailed by the front door. If a player had been especially lucky and felt good he usually put in a nickel or a dime and occasionally a quarter. Sometimes, too, if a player had been having a poor run of dominoes he might drop in a coin, hopefully to change his luck. Incidentally, the club was always in the black.

Of course, membership is not limited to Myrtlewood. Some live 20 to 30 miles away, and old members who have moved ofttimes drive 50 to 60 miles and spend the night with friends on Friday night.

Knowledgeable citizens vow and declare that the club is the greatest asset in the county. It is said that members insist on their dinner at 12 noon, and take a nap, then about 1:30 they get the "willies." They "tidy themselves up," check their hair and commence looking out the window if someone is to pick them up. Some check their hearing aids and wash their glasses. One of the chief members who gives several a ride, is said to always crank his car at 1 o'clock and let it run a few minutes, thus insuring a prompt response at 1:45. Usually his "pick-ups" are waiting at the curb. There is no doubt that the therapeutic aspects are outstanding, not only to the members, who look forward to the game every afternoon, but to the wives who are free and do not have them underfoot.

Fred kept bedevilling me about whether I had the qualifications to join. He went on to relate that they had judges, lawyers, farmers, preachers, railroad men, clerks, etc., but no doctors. I knew what he wanted and finally asked, "What are the qualifications?" Here they are . . .

Answer the following, "yes" or "no":

1. Do you work?
2. Would you work if offered a regular job?
3. Does your wife enjoy having you sit around the house in the daytime?

A "yes" to any of the above questions disqualifies you.

Now two more:

1. Are you on Medicare or Medicaid?
2. Can you see spots on dominoes, or hear a dinner bell?

A "no" to either question disqualifies you.

I qualified. The only stumbling block is that I have to learn how to play "block dominoes" before being granted full membership.

the association
the association
the association

NEW MEMBERS

Cabezas, Rodrigo, MAA—Act—TS
4555 N. Shallowford Road, Atlanta 30341

Colon, Luis M., Baldwin—Act—ObG
Clodfelter Apt. 2, C.S.H., Milledgeville 31061

Encinas, Senen J., Jefferson—Act—FP
1067 Peachtree St., Louisville 30434

Espy, Paul D., Cobb—Act—D
114 Cherry St., Suite E., Marietta 30060

Evans, Frank O., Jr., Baldwin—Act—I
511 N. Cobb St., Milledgeville 31061

Gall, Henry, Thomas Area—Act—FP
5 First St., N.E., Thomasville 31792

Garcia-Rivera, Carlos, Baldwin—Act—FP, P
Central State Hosp., Milledgeville 31061

Grant, Larry W., Bibb—Act—I
50 N. Medical Dr., Salt Lake City, Utah 84112

Grow, William R., S. Ga.—Act—I
311 Woodrow Wilson Dr., Valdosta 31601

Harper, Meredith, Coffee—Act—ObG
1001 W. Ward St., Douglas 31533

Harrison, Jacob R., Jr., Whitfield-Murray—Act—ObG
1217 Memorial Dr., Dalton 30720

Henderson, Kenneth C., Bibb—Act—Pd
777 Hemlock St., Macon 31208

Henry, George M., Bibb—Act—P
1055 Walnut St., Macon 31201

Ingraham, Roddy P., Whitfield-Murray—Act—FP
Pediatric Clinic, Dalton 30720

Jansen, George A., Whitfield-Murray—Act—Anes
Hamilton Mem. Hosp., Dalton 30720

Kumar, Veeni S., Cobb—Act—Path
737 Church St., Marietta 30060

Lee, Kuo Lam, Coffee—Act—R
P.O. Box 1077, Douglas 31533

Malcom, George E., Jr., Cobb—Act—EM
Kennestone Hospital, Marietta 30060

McBride, Michael T., S. Ga.—Act—ObG
305 University Dr., Valdosta 31601

Miller, William S., Whitfield-Murray—Act—FP
Hamilton Mem. Hosp., Dalton 30720

Podobnikar, Michael F., Clayton-Fayette—Act—Su
P.O. Box 335, Stockbridge 30281

Raghu, G. V., Peach Belt—Act—ObG
507-B N. Houston Road, Warner Robins 31093

Ravita, John S., Baldwin—Act—FP
264 W. Green St., Milledgeville 31064

Razuri, Rafael G., Ga. Med. Soc.—Act—Su
5105 Paulsen St., Suite 140, Savannah 31405

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Med. Arts Bldg., Dalton 30720

Schmidt, Richard E., Bartow—Act—EM
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839 First St., Macon 31201

Teaford, Henry St. George, Jr., Sumter—Act—Su
629 E. Forsyth St., Americus 31709

Urrutia, R. V., Jr., Cobb—Act—Or
114 Ivy Lane, Petersburg, Va. 23803

Valdecanas, Virgillio Q., Baldwin—Act—Su
P.O. Box 1151, Milledgeville 31061

SOCIETIES

The September meeting of the **Bibb County Medical Society** featured a program, "The Pattern and Philosophy of Professional Nursing Education," arranged by the Professional Education Committee of the society. Speakers were: Dr. William Wright, president of Macon Junior College talking on "The Associate Degree Program"; Catherine Summerlin, director of the Department of Nursing Education at Georgia College in Milledgeville on "The Baccalaureate Degree Program"; Mrs. Linda Greenwood, director of the School of Nursing at Medical Center of Central Georgia in Macon on "The Diploma Program"; and Mrs. Sandy Bond, Director of Nursing at the Medical Center of Central Georgia on "Inservice Education Program in Development of Nursing Skills."

William Jenkins, Director of Georgia's Disability Determination Unit and Richard Smoot, M.D., medical consultant, were guest speakers at the September meeting of the **DeKalb County Medical Society,** addressing the topic, "Disability Determination Unit of Vocational Rehabilitation—How It Affects You and Your Patients." The Society has prepared a "new member kit" for new physicians entering practice in DeKalb County which presents the business side of a medical practice from licensure to insurance. In November DeKalb physicians will meet with the DeKalb County Bar Association at the Atlanta Athletic Club.

The **Medical Association of Atlanta** has announced the dates for the 1976 Atlanta Graduate Medical As-

sembly which will be March 14-17, 1976 at the Omni International Hotel. The theme for the program will be "Concepts and Controversies in Medicine and Surgery."

PERSONALS

First District

Elton S. Osborne of Savannah was featured in the *Savannah Morning News* in September when fellow residents of a Tybee Island nursing home honored him on his 99th birthday, which was on Labor Day. Dr. Osborne retired two years ago after 75 years of practice. He is the oldest member of the Georgia Medical Society.

Fourth District

Five members of the DeKalb County Medical Society were honored in September by Dr. James H. Hinson, Jr., superintendent of the DeKalb School System. **Drs. William Walker, O. Wytch Stubbs, Jr., Timothy Harden, Garland P. Bennett, Jr.** and **Eldon E. Hoose** were awarded honor plaques at a dinner meeting for their help in the school system's athletic program by giving physical examinations and medical services at no charge.

Fifth District

New executive associate dean of Emory University School of Medicine is **Dorothy Brinsfield,** M.D., who succeeds **Dr. Evangeline Papageorge.**

Donald S. Bickers of Atlanta was presented the Professional Achievement Award of the Georgia Rehabilitation Association at its annual convention at Jekyll Island in August. For 20 years Dr. Bickers has conducted a seizure clinic for epilepsy patients for the Epileptic Foundation and Vocational Rehabilitation, allowing patients to prepare for employment situations.

Clinton D. McCord, Jr. of Atlanta will serve the AMA as a member of the Program Committee for the Council on Ophthalmology.

John M. Roberts, Atlanta, will be course director for the Southern Medical Association's postgraduate course, Recent Advances in Children's Orthopedics (Nov. 16), at SMA's 69th Annual Scientific Meeting in Miami Beach.

Clinton E. Warner, who has practiced in Atlanta since 1956, has been appointed to the Fulton-DeKalb Hospital Authority for a term expiring at the end of 1978.

Sheldon B. Cohen will serve as clinical editor of the *American Journal of Clinical Hypnosis.*

Ronald P. White, director of emergency services for Georgia Baptist Hospital in Atlanta, has been elected to a three-year term on the Board of Directors for the American College of Emergency Physicians. Dr. White has been active with ACEP by serving on several committees. He served as chairman of the Georgia Chapter and is an ACEP councilor from the state.

Charles E. Dowman of Atlanta was honored in Hayesville, North Carolina September 13 with a "Doctor Dowman Appreciation Day" planned by patients in the Hayesville area cared for by him over the past 30 years. Festivities included a sight-seeing tour of parts of Clay County, a seated dinner and presentation of gifts and a commemorative plaque to Dr. and Mrs. Dowman.



Dr. Ross (L) receives Heart of the Year Award from GHA President Robert G. Ellison.

Thomas L. Ross, Jr., Macon cardiologist, has received the Heart of the Year Award, the Georgia Heart Association's highest award for volunteer leadership in the fight against heart disease.

The heart-shaped plaque was presented by GHA president Robert G. Ellison, M.D., of Augusta during the GHA's 27th Annual Meeting in Atlanta September 12.

Dr. Ross, who is deputy coordinator of the Georgia Regional Medical Program, has been active with the Heart Association at the national, state and local levels for more than a quarter of a century. He served on the American Heart Association's board of directors for six years and received the AHA's Award of Merit.

A founding member and past president of the Georgia Heart Association, he has helped guide and develop volunteer programs of the association throughout its 27-year history. Dr. Ross founded the GHA heart clinic at the Medical Center of Central Georgia (formerly Macon Hospital) and served as its chief.

He is a graduate of Mercer University and Emory University School of Medicine.

Eighth District

William Grow has joined the staff of South Georgia Medical Center in Valdosta. He is a graduate of the Medical College of Georgia.

After 11 years of practice in Jesup, **William A. Hitt**

and his family are moving to St. Simons where he will open a family practice office.

V. C. Wade, formerly of Valdosta, has opened a family practice office in Americus. He is a graduate of the Medical College of Georgia and served as a Naval aviator during World War II.

Ninth District

Tom Lumsden of Clarkesville is serving on the Steering Committee of the Georgia Mountains Health Advisory Council which will develop a health systems agency for the area.

Tenth District

Curtis H. Carter has ended a three-year period as dean of the School of Medicine at the Medical College of Georgia in order to resume duties as a professor of medicine. Dr. Carter became associate dean for clinical sciences in 1968, became acting dean of the School of Medicine in 1971 and was named dean in July 1972.

William B. Strong, Augusta, has been appointed to the American Academy of Pediatrics Committee on the Pediatric Aspects of Physical Fitness, Recreation and Sports.

Paul R. Dyken has been appointed chairman of the ad hoc committee of child neurology for the Society on Developmental Pediatrics.

Sam A. Threefoot of Augusta has been named to receive an Award of Merit for outstanding service to the American Heart Association. Chief of staff at Forrest Hills Division, Veterans Administration Hospital, and assistant dean and professor of medicine at the Medical College of Georgia, he was cited for "dedicated and distinguished service in advancing the American Heart Association's national program designed to reduce death and disability from the diseases of the heart and circulation." The award will be presented during a meeting of the AHA board of directors in New York City early next year. Dr. Threefoot is chairman of AHA's council on circulation, member of the nominating committee and member-at-large of the executive committee.

DEATHS

Clark Howell Bryant, Sr.

Retired physician Clark Howell Bryant, 76, died August 2 at his home.

Dr. Bryant was born in Oglethorpe County, attended Georgia Military College at Milledgeville, the University of Georgia, and was graduated from Emory Medical School in 1925. His internship was served at Georgia Baptist Hospital and he opened practice in Comer in 1927.

He was a member of the Clarke County Medical Society, Masons, Athens Shrine Club, Comer Lions Club and the Comer Baptist Church.

Survivors include his widow, Mrs. Sarah Hughes Bryant; son, Clark H. Bryant, Jr. of Dayton, Ohio; sisters, Mrs. Clyde Ford of Atlanta and Mrs. John Erickson of Tavares, Fla.; three grandchildren.

Thomas Pope Goodwyn

Retired orthopedic surgeon, Thomas Pope Goodwyn of Atlanta died September 14 at the age of 83. Dr. Goodwyn, Emory graduate, was chief of orthopedic services at Grady Hospital for 30 years and served as president of the visiting staff at Grady, Georgia Baptist and Crawford W. Long hospitals.

Dr. Goodwyn served with the medical corps of the American Expeditionary Forces during World War I and served with the Georgia State Guards during World War II.

He was a past president of the Medical Association of Atlanta, charter member of the Southeastern Surgical Association and American Academy of Orthopedic Surgeons, and a member of the American College of Surgeons and the American Board of Orthopedic Surgeons. He was a Mason, Shriner and served on the Board of Deacons at the Second Ponce de Leon Baptist Church. Dr. Goodwyn was on the advisory board of the Crippled Children's Program and was a medical consultant to the Division of Vocational Rehabilitation.

He is survived by his widow, the former Edna Paulk; and daughter, Mrs. James H. Mapp of Ft. Rucker, Ala.

John Ransom Lewis

John Ransom Lewis, 84, of Louisville, who served Jefferson County many years as a physician and as county commission chairman, died September 1 in an Augusta hospital after a long illness.

Born in Union Point, the son of a Methodist minister, Dr. Lewis was graduated from Young Harris College and the Medical College of Georgia, class of 1915. His son is John R. Lewis, Jr., M.D. of Atlanta, plastic surgeon and poet laureate of Georgia.

Dr. Lewis began practice in Louisville in 1916, and for 38 years also served as a Jefferson County commissioner, all but six years as chairman. He was a Mason, Shriner, member of the Louisville Kiwanis Club and United Methodist Church. He had been given an honorary humane letters degree from Reinhardt College in Waleska.

Dr. Lewis is survived by his widow, Mrs. Ethel Boone Lewis; daughter, Mrs. James W. Pilcher, Louisville; son, John R. Lewis, M.D., of Atlanta; and sister, Mrs. O. O. Etheridge, Louisville.



Members of the newly-formed Governor's Medical Malpractice Advisory Council are sworn in during ceremonies August 14 in the Governor's office. They include (L-R) Richard B. Thornton, Macon; Bobby Dwelle, Millen; W. Daniel Barker, Atlanta; Charles E. Hollis, Jr., M.D., Albany, who is chairman; William Ferguson, Atlanta; Robert E. Wells, M.D., Atlanta; Gov. George Busbee; Charles Chaffin, Macon; and Glenn Frick, Atlanta. Dr. John F. Adams of Georgia State University's Center of Insurance Research was not present. The Council was formed to research the problem or potential problem of medical liability insurance for physicians and other health care providers in the state. The findings of the Council, made up of physicians, lawyers and hospital administrators, will be presented to the Governor prior to the convening of the 1976 Georgia General Assembly. In addition, a Health Laws Study Committee has been formed consisting of James A. Kaufmann, M.D., Otis T. Hammonds, M.D., Richard V. Gadd and Frank M. Bird, Jr., all of Atlanta.

AMERICAN DIABETES ASSOCIATION SCHEDULES GEORGIA MEETING NOVEMBER 22

Mrs. Anne R. Somers will be the principal speaker for the Annual Meeting of the Georgia Affiliate of American Diabetes Association on Saturday, November 22, 1975, at the Academy of Medicine, 875 W. Peachtree St., NE, Atlanta. Mrs. Somers holds an honorary Doctor of Science degree and is a well-known author, lecturer, teacher and health care administrator who has been engaged for more than two decades in health and health care studies and activities. She is associate professor in the Departments of Community Medicine and Family Medicine, College of Medicine and Dentistry of New Jersey-Rutgers Medical School. She is also a research associate, Industrial Relations Section, Princeton University.

The subject of Mrs. Somers' address will be "Patient Education as an Essential Aspect of the Care of the Diabetic." She is scheduled to appear on the program at 11:15, following two workshop sessions.

Registration for the meeting will begin at 8 a.m. and the first workshop will follow promptly at 8:45. A panel of several members of the Georgia Dietetic Association will discuss concepts of dietary management for the diabetic. Included in this will be cholesterol, fat, and sodium restrictions. Time will be reserved for a question and answer period. A list of available resources and services in various areas of the state will be supplied.

After a brief recess, the second workshop will convene at 10:15. Dr. David E. Dalrymple, program chairman, will moderate a panel of health professionals including specialists in various fields, an internist, a podiatrist and a registered dietitian. They are Drs. John A. Davidson, ophthalmology; Stewart Wiegand, dermatology; Ann Kinzer, podiatry; and John D. Cantwell, director of Atlanta's Preventive Cardiology Clinic and a well-known authority on preventive and rehabilitative exercise. Each of these areas of specialization is of particular importance to the diabetic due to the various aspects of complications which can develop.

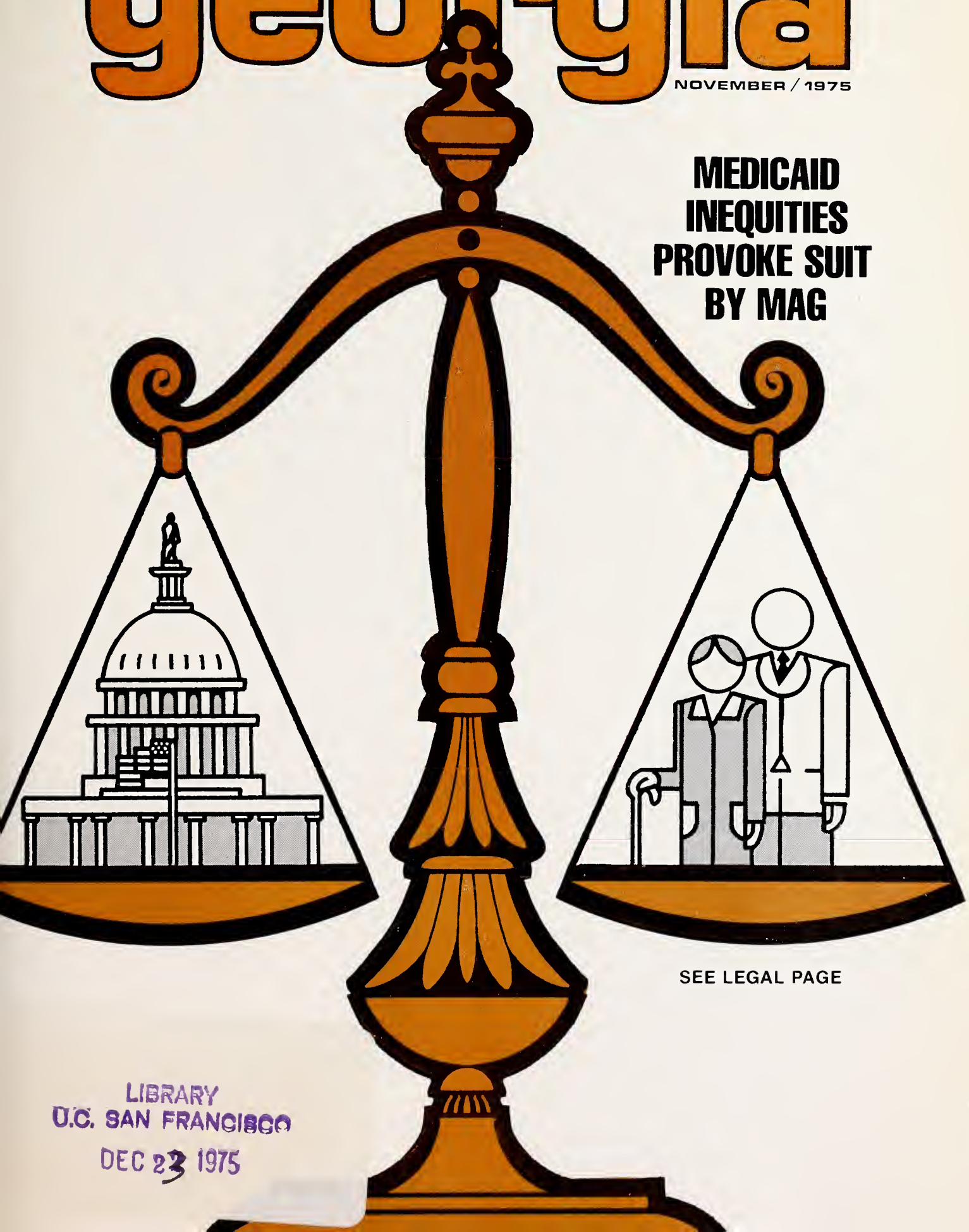
Joining these professionals on the panel will be Dr. Kay McFarland, an internist in Augusta with extensive training and experience in treating diabetes, and Mrs. Marge McGinty will serve this group as the registered dietitian. The panel will discuss good diabetic care, prevention of complications, and treatment of complications when they do occur.

A lunch break will follow Mrs. Somers' address, after which a business meeting will be brought to order at 2 p.m. Included on the agenda will be reports from each of the 10 chapters of American Diabetes Association in Georgia, committee reports, and election of 1976 Officers and Board of Directors of the Association. The newly-elected Board will convene immediately after the general meeting concludes.

The public is invited to participate in the meeting. Information concerning registration can be obtained from any chapter or from the Diabetes Center, 762 Cypress St., N.E., Atlanta, Georgia 30308, telephone (404) 881-1963.

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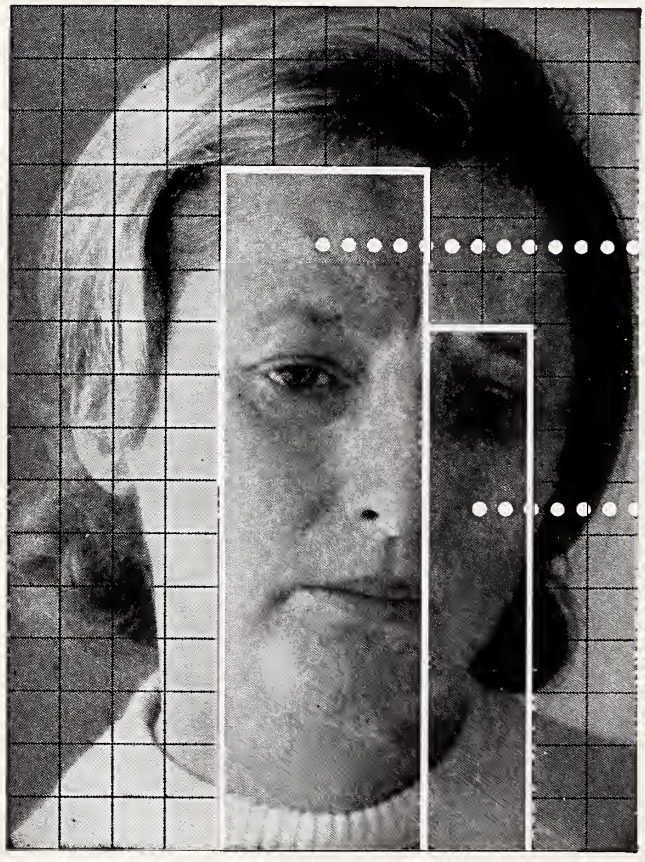
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Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1975, Medical Association of Georgia.

Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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Management of Bronchopleural Fistulas Following Pulmonary Surgery

BHONGTEP SINGHABHANDHU, M.D. *and* **ALBERT H. BRIDGMAN, M.D.,** ***Thailand and Oteen, North Carolina****

BRONCHOPLEURAL FISTULA remains a serious complication following pulmonary resection in terms of morbidity and mortality. Malave et al.[5] reported an incidence of 2.7 per cent following pulmonary resection for all kinds of pulmonary pathology. These frequency rates are impressively high when the resection is done for tuberculosis (6.7 per cent)[4] or following pre-operative radiation treatment for bronchogenic carcinoma (15.5 per cent).[7] The presence of infection in the pleural space and postoperative empyema predispose to the development of this complication (case 2). The purpose of this paper is to report our experiences with the management of bronchopleural fistula.

Details of Case 1

A 62-year-old white male was admitted because of hemoptysis, productive cough and dysphagia. Esophagoscopy showed esophagitis and bronchoscopy revealed a lesion in the right intermediate bronchus which proved to be squamous cell carcinoma by biopsy. On February 28, 1972, a right radical pneumonectomy was done. The bronchial stump was closed with the stapler. A bronchopleural fistula developed approximately two weeks postoperatively and manifested as sudden expectoration of a large amount of bloody material and temperature elevation. Chest X ray showed decrease in the air fluid level in the pneumonectomy space. Bronchoscopy confirmed the presence of an open bronchial stump. The patient underwent an upper limited thoracoplasty involving the resection of ribs No. 1 to No. 4 on March 22, 1972. An intercostal muscle flap was used to close the open bronchial stump. Monofilament steel No. 2-0 wire was utilized to suture the muscle flap to the bronchus. Permanent dependent drainage of an Eloesser type was constructed by resecting portions of the 7th and 8th ribs. It should be mentioned that there was no gross empyema in the pleural space at any time during the patient's course. Postoperatively, the patient did well and the fistula healed without complication. The patient was discharged and the drainage site was irrigated daily using half-strength hydrogen peroxide. The patient has a history of hypertension and arteriosclerotic heart disease with episodes of congestive heart failure requiring diuretics and digitalis. He developed transient right arm paresis two years after thoracoplasty. Because of these medical problems, no further attempts have been made to close his empyema space.

Case 2

A 47-year-old white male was transferred to Oteen Veterans Administration Hospital from a private hospital for surgical treatment with a cavity in the left lung apex which was not responsive to extensive antibiotic treatment. He was suspected of having lung abscess or cavitating neoplasm. His intermediate PPD skin test was nonreactive. In his social history, the patient drinks alcoholic beverages rather heavily and smokes one to two packs of cigarettes a day. Bronchoscopy was not informative. The patient underwent left thoracotomy and wedge resection of the apical-posterior segment of the left

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upper lobe was carried out. The pathological report of the specimen was a chronic granulomatous pleurisy with a large cyst (4 cm) formation and organizing pneumonitis. After operation, the patient spiked fever up to 101-102° F. His postoperative chest X ray revealed progressive opacification of the remaining left lung. Bronchoscopy disclosed a large amount of blood in the left bronchial tree which was vigorously aspirated. The culture grew out Klebsiella, sensitive to Keflin and Chloromycetin. The patient became more and more toxic in spite of the use of massive doses of antibiotics in combination, namely, Keflin and Garamycin. Finally, the patient underwent complete pneumonectomy on March 7, 1974. The removed lung showed severe suppurative pneumonitis and areas of infarction. The bronchial stump was closed with the stapler. His initial postoperative course was encouraging. His febrile course was declining and he appeared less ill. However, three weeks after pneumonectomy, the patient developed severe paroxysms of coughing, especially when he lay on the opposite side, raising a large amount of bloody material. Chest X ray showed change in the air fluid level in the pneumonectomy space. The chest tube was inserted and the drainage was similar to the material that he coughed up. One week later the closed chest tube drainage was converted to open drainage of Eloesser type. The patient became afebrile and remained so when he was discharged. Bronchoscopy disclosed a small fistula at the stump confirmed by bronchogram. His wife was instructed to irrigate the cavity daily using hydrogen peroxide. Also one quarter per cent Neomycin solution was prescribed for short term use. Broad spectrum antibiotic was prescribed. The patient was readmitted about two months later for the care of the pleural space in the form of daily debridement and cleansing with hydrogen peroxide. The Betadine aerosol spray administered into the pleural space was found to be effective to keep the area clean. On June 11, 1974, the patient underwent complete thoracoplasty, parietal decortication and closure of the fistula utilizing intercostal muscle pedicle for grafting. Since he had collapse of the whole chest wall, the stump closure was not air-tight in this case. The patient did well after surgery. The fistula has closed a few months later.

Discussion

Bronchopleural fistula occurs most frequently during the first two postoperative weeks. The important signs are fever, persistent air leakage from the chest tube, sudden expectoration of liquid materials, bloody or purulent, often similar to the drainage from the chest tube. A diagnostic thoracentesis for smear and culture disclose the empyema. The character of the aspirated fluid may vary from bloody in the early postoperative, to purulent, thick material in the late postoperative periods. Occasionally, pleurocutaneous fistula develops through the incision. The characteristic radiological findings are decrease of the air fluid level in the pneumonectomy space, appearance of air pockets which were not present previously. (Figures 1 and 2) The diagnosis may be confirmed by bronchoscopic examination or by

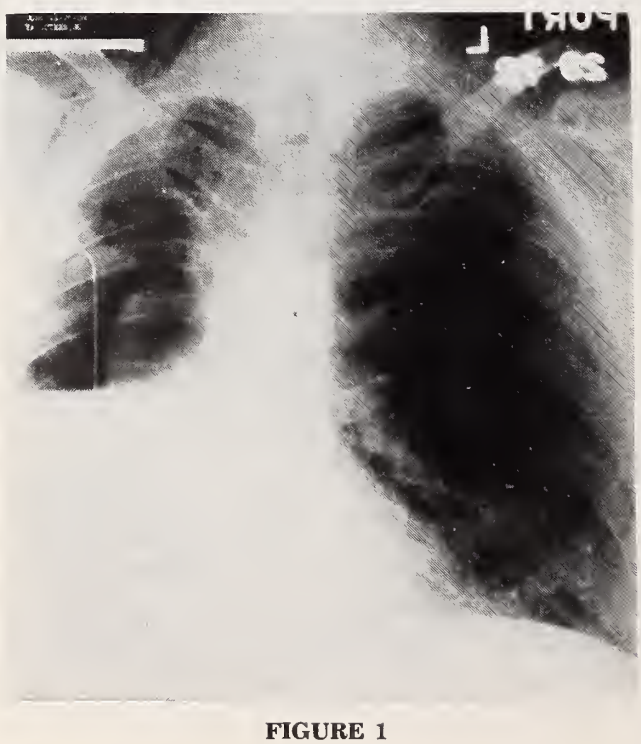


FIGURE 1



FIGURE 2

bronchogram. (Figure 3) Methylene blue injected into the empyema cavity may be expectorated in the sputum.

Management

Small bronchopleural fistula with empyema thoracis secondary to lung infection may eventually close spontaneously if the lung infection is cleared up. Many will close spontaneously after lung decortication, adequate drainage or collapsing operation on the thoracic wall. Because there is direct communication between the tracheobronchial tree harboring florid organisms and the pleural cavity, the blood or serofibrinous transudate within the space is constantly invaded by these pathogens. Appropriate antibiotics directed against these organisms should be instituted.

Initially, conservative measures such as repeated aspirations or closed chest tube drainage may be tried to empty the empyema cavity. In addition, antibiotic solution may be instilled into the pleural space through the chest tube or after each aspiration. Occasionally, empyema with small bronchopleural fistula may be successfully treated in this manner until the space following lung resection becomes sterile allowing spontaneous healing of the fistula. Clinically significant bronchopleural fistula will require adequate open drainage. When the fistula is large, the danger of flooding the normal lung is imminent. Under this circumstance, the tube drainage should be converted to open drainage with rib resection. We prefer to resect at least two ribs and construct a modified Eloesser flap, namely, creation of the skin-lined opening by suturing the skin or subcutaneous tissue to the parietal pleura. Adequate chest tube drainage is also indicated in the early postpneumonectomy period for the evacuation of the empyema when the mediastinum has not become stabilized.

Following the open drainage and rib resection, the pleural cavity may be treated with daily irrigation using antibiotic or antiseptic solution. Half-strength Dakin's solution works well to remove the debris in the empyema space. It is, however, contraindicated when bronchopleural fistula is present. This solution in the bronchial tree will produce coughing. Long term use of Neomycin solution for intrapleural instillation may cause damage to the eighth cranial nerve, to the kidney, and respiratory paralysis. Comparable plasma level to the oral dose of three grams a day has been detected after intrapleural instillation of one quarter per cent Neomycin solution.[2]

Following the open drainage, the size of the pleural cavity will decrease slowly by displacement of the diaphragm, mediastinal shifting, and fibrous organization in the cavity. A sufficient length of time, at least two or three months, should be allowed to let the patient recover fully from previous operation and to regain his nutritional status prior to the next operation. This waiting period will allow the physician to better observe and predict the natural course of the disease. After pneumonectomy, the majority of the patients will require thoracoplasty to reduce the pleural space at the time of the definitive stump closure. Thoracoplasty is not indicated in a poor risk patient or in those with a short life expectancy.



FIGURE 3

Thoracoplasty may be carried out in one or more stages at the time of the stump closure. Closure of the bronchial stump alone by resuture or by the use of muscle pedicle is seldom justified due to the presence of infection. Abrashanoff,[1] the Russian surgeon, is credited with the first report on the use of pedicle muscle for the closure of bronchopleural fistula. Since then, the grafting of the pedicle muscle has been used successfully by others.[6, 8] Barker et al.[3] reported a good result utilizing pectoral muscle pedicle for the closure of the open stump following lung resection. Here, the pectoral muscle was divided close to the humerus and brought down to fill the space and cover the fistula. They emphasized the need to fill and cover the pleural space and, therefore, it is not feasible when the space is large without additional thoracoplasty. Following pneumonectomy, we have been using intercostal muscle pedicle for the closure of the bronchopleural fistula with thoracoplasty. Limited thoracoplasty with a dependent opening for the drainage or complete thoraco-

plasty has been done. We find that it has become easier for the patient to take care of the smaller space with less frequent recurrence of infection. As a result, they recover faster to undergo final closure or complete thoracoplasty.

Summary

Two cases of bronchopleural fistula following pneumonectomy are presented. Thoracoplasty (in single or multiple stages) combined with definitive closure using intercostal muscle pedicles seem to work well in postpneumonectomy patients. It is used only in patients considered to be good risk and those with good longevity. ■

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HIGHLIGHTS OF EXECUTIVE COMMITTEE

Saturday, October 12, 1975

Medicaid Lawsuit: Received the report that the MAG lawsuit was filed on Thursday, October 9, in federal court in Atlanta. The suit is being brought against F. David Mathews, Secretary of HEW; George Busbee, Governor of Georgia; T. M. Parham, Commissioner of the Georgia Department of Human Resources; and Sam T. Thurmond, Director of Medicaid. The plaintiffs named in the suit are the MAG for its members; Drs. C. E. Bohler of Brooklet and J. W. Chambers of LaGrange as providers; and two of Dr. Chambers' patients as Medicaid recipients. Legal counsel states that the court will hear the MAG request for a temporary injunction in three to four weeks.

Medicaid Manual—Proposed Changes: Received a report that DHR is proposing changes in the Medicaid Manual. The Executive Committee agreed not to comment at this time because the Association is suing to do away with the manual altogether.

MAG Services, Inc.: Approved the establishment and incorporation of an MAG subsidiary to operate the print shop and any other membership services that may be developed in the future. This is being done to protect the MAG's tax-exempt status.

National Health Service Corps: Approved a request for National Health Service Corps physicians to be assigned to the Brooks County area.

MAG Newsletter: First issue to be published between October 20-25. Monthly thereafter.

Nominations and Appointments: Charles Underwood, M.D., Marietta, to represent Council on Interspecialty Council. John A. Harrel, Jr., M.D., Decatur to serve on the Subcommittee on Public Education of the Education Committee.

EMS Committee: Approved a request for funds to send an MAG representative to attend a meeting in New York City on Airport/Community Emergency Medical Preparedness.

Redesignation of Committee: Approved the change from ad hoc status to special status for the Committee on Laboratory Quality.

September 1976 Council Meeting: Approved the Cloister as the site because there were no other suitable facilities available for the dates selected by Council (September 18-19). In 1976 the January, June and September Council meetings will begin on Saturday morning, Saturday afternoon will be free and the meeting will conclude on Sunday morning.

This twelve year follow-up shows that the proper reduction must be done to preserve the function of the index finger.

The Natural History of an Unreduced Dislocated Index Finger Metacarpophalangeal Joint in a Child

JAMES L. BECTON, M.D. *and* AUGUSTIN S. CARSWELL, M.D., *Augusta**

THE DISLOCATED metacarpophalangeal joint of the index finger is a complex hand injury problem and can seldom be reduced by closed techniques. Kaplan[5] has shown that in the dislocated position the metacarpal head becomes trapped between the volar plate on the dorsum of the head, the lumbrical muscle on the radial side, the profundus and sublimis tendons on the ulnar side and the thick palmar fascia on the volar side. The entraping mechanism of this configuration of soft tissues is aggravated by traction on the finger in an effort to reduce it.

The authors[1, 4, 7–9] writing on this subject have each reported their collected series of cases; no series has been very large, in fact, most are case reports. They have all stressed the need for opening the joint for proper reduction of the joint to its anatomical position. However, none of them has reported on a case that was left unreduced and followed for many years. Lipscomb[6] reported on a 20 year follow-up of an unreduced dislocation of the thumb metacarpophalangeal joint. We have been unable to find a previously reported case of a long term follow-up of an unreduced dislocation of the metacarpophalangeal joint of the index finger. It is the purpose of this paper to report on a 12 year follow-up of such a case with X rays showing the initial injury and the long term findings.

Case Report

In 1973, a 19-year-old boy presented at the infirmary of the state school where he was living with an injury to his right hand. The history and physical examination showed that he had sustained a recent minor contusion of his hand. It was also noted at



FIGURE 1

X ray taken on the day of injury. Note the torus fracture of the proximal phalanx of the index finger. Also note the dislocation of the index metacarpophalangeal joint.



FIGURE 2

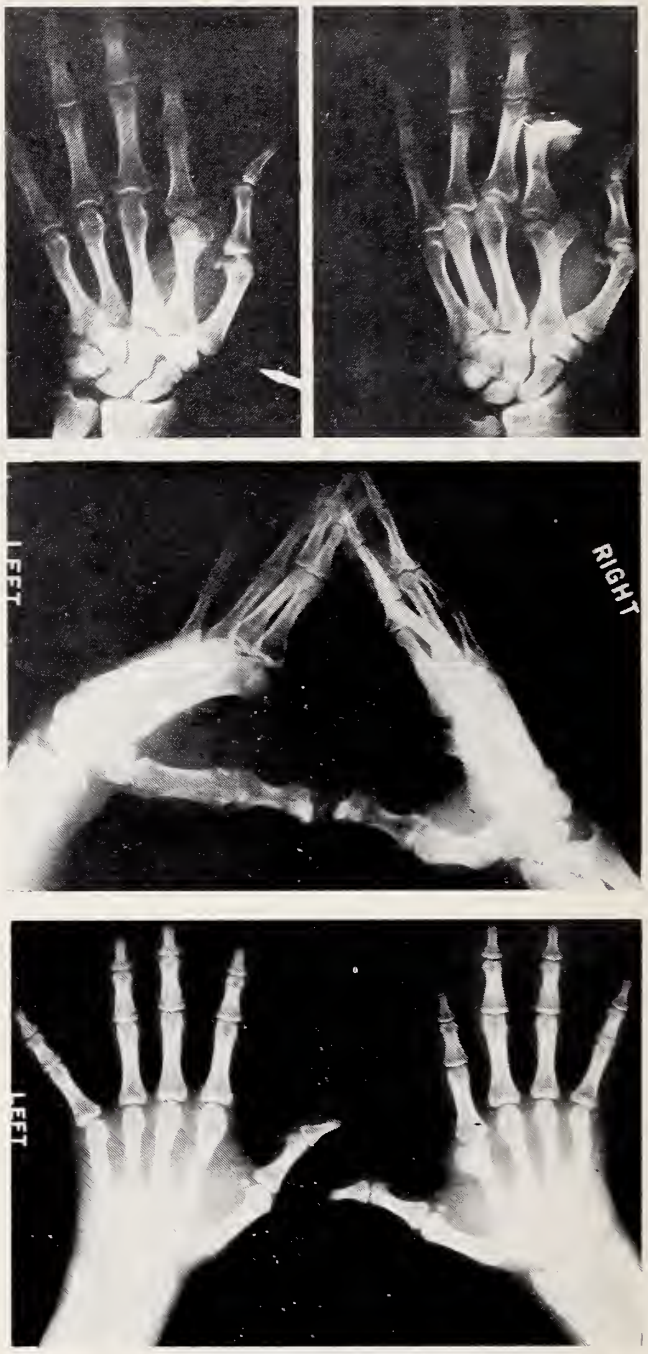
X ray taken 10 days post injury.

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that time that the index ray was short on the right as compared to the left and there was limited flexion of the MP joint on the right as compared to the left. This was not the area of his recent injury. A bony mass was palpable in the palm in the area of the index metacarpal head.

An X ray of the hand showed a bony mass on the volar side of the index metacarpal. All previous X rays which had been made of this patient during his past 15 years of being institutionalized at this state school were available. These were reviewed. In 1961 he had sustained an injury to his hand and was treated by the attending medical student. These X rays showed a torus fracture of the proximal phalanx of the index finger which was recognized and treated with a metal splint. However, the dislocated index MP joint was not recognized. The patient's medical record also was available for review. Recheck X rays one and two weeks later showed the fracture healing in good position. The dislocation was still present but not recognized by the attending physician. The medical records show that the splint was removed and patient dismissed after the third set of X rays of the hand.

The bony exostosis was the old index metacarpal head. A new metacarpal head had regenerated on the dorsal side of the old metacarpal head. This index metacarpal is 13 mm shorter than the index metacarpal on the left hand.



FIGURES 3, 4, 5

X ray taken 12 years following initial injury. The two metacarpal heads are shown with the regenerated metacarpophalangeal joint and old metacarpal head on the volar and radial aspect of the shaft of the metacarpal.

Discussion

This case demonstrates once again the necessity for a proper examination of the hand followed by a detailed evaluation of the X ray of the hand when a child has been injured. A severely swollen hand in a crying child is sometimes very difficult to evaluate. The finding of one fracture should make a surgeon look even more closely for another associated injury of the hand. The value of a recheck X ray is not only to establish the satisfactory position and healing of a fracture but is an opportunity to re-evaluate the injured areas again for other fractures or dislocations.

The natural remodeling ability of the musculoskeletal system of a child is well demonstrated by this case. It is interesting to note that a new joint with associated ligaments formed around the regenerated metacarpal head. There is only slight overall shortening of the index ray.

Lipscomb[6] in the discussion of his case of the 20 year follow-up on the dislocated metacarpophalangeal joint of the thumb states: "It is fortunate that the growth center of the first metacarpal is at the proximal end because a similar injury to the other metacarpals might lead to progressive deformity and marked shortening." This speculation is true as is shown in this case.

The index metacarpal is a stable metacarpal and the dislocation of the metacarpophalangeal joint is actually that of the proximal phalanx on the dorsum of the metacarpal head.

Noting the characteristic attitude of the digit when the joint is dislocated is helpful in establishing the



FIGURE 6

Photo of both hands showing flexion of the metacarpophalangeal joints of the index fingers.



FIGURE 7

The index finger is shorter on the right and there is a mass in the palm.

diagnosis. The proximal phalanx is hyperextended and the PIP joint is in flexion. The dislocation is best seen by a true lateral view of the hand rather than an oblique view which is so often taken. These findings associated with a high degree of suspicion by the surgeon will lead to better care of the child with an injured hand.

This case shows that the natural history of the unreduced dislocated index metacarpophalangeal joint results in slight shortening of the index ray and formation of a new joint and metacarpal head. The function of the finger is so poor that it is bypassed for precision grip but used in gross hand function. The need for proper reduction of the dislocated index MP joint for long term useful function is obvious. ■

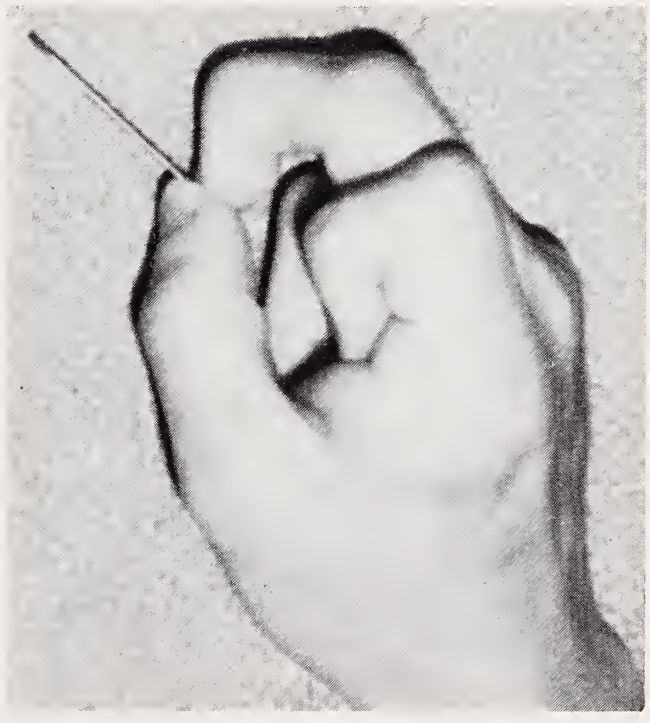


FIGURE 8

The index finger is bypassed when picking up small objects.

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The authors conclude that this is the best means available for differentiating benign from malignant tumors of the choroid.

Ten Years Experience With the Radioactive Phosphorus Uptake Test in the Diagnosis of Uveal Malignancy

WILLIAM H. JARRETT, II, M.D., WILLIAM S. HAGLER, M.D., JOHN H. KILLIAN, M.D. *and* JAMES H. LAROSE, M.D., *Atlanta**

THE DIAGNOSIS and management of tumors of the uveal tract is one of the most challenging and difficult tasks confronting the ophthalmologist. Two major forms of malignant tumors occur in the uvea: primary malignant melanoma of the uvea, and neoplasms metastatic to the uvea from a primary site elsewhere in the body. However, a variety of non-neoplastic lesions may also involve the uveal tract and mimic a potentially lethal tumor. The problem is to differentiate the former from the latter because proper management depends on accurate and precise diagnosis.

A number of recent studies in the ophthalmic literature attest to the difficulties encountered in making this differential diagnosis.[1–4] The study by Ferry in 1964, and updated by Shields and Zimmerman in 1973, indicates that approximately one eye in five removed with the clinical diagnosis of malignant melanoma does not, in fact, contain a melanoma. Eyes containing benign lesions such as choroidal hemangioma, choroidal nevus, serous or hemorrhagic detachment of the retinal pigment epithelium, or melanocytoma of the optic nerve head have been unnecessarily removed. And this, of course, is only one side of the problem viewed from the standpoint of the ocular pathologist examining material submitted to his laboratory. What about those eyes harboring malignancies which go undiagnosed, but which should be removed?[5–6] How many eyes, for example, undergo scleral buckling surgery for retinal detachment, when, in actual fact, the detachment is not a rhegmatogenous one, but is secondary to a choroidal tumor?[7, 8] A malignant tumor of the uveal tract is a potentially lethal disease; even the "benign" Spindle A melanoma carries a significant five year mortality. Thus it behooves us as clinicians to separate out the benign from the malignant tumors and treat the patient accordingly.

How do we go about making this differentiation clinically? There is no question that a careful examination of the ocular fundus, utilizing stereoscopic binocular indirect ophthalmoscopy, slit lamp fundus contact lens, and fluorescein angiography will lead to the correct diagnosis in the vast majority of cases, probably 90 per cent or better. But nonetheless, there remain a number of cases where the clinical diagnosis is uncertain. Biopsy of the lesion in the wall of the eye is not recommended, because (1) the procedure itself is hazardous and might result in loss of useful vision, and (2) if the lesion being biopsied is a neoplasm, the procedure might spread the tumor into the orbit.

In our hands the most useful tool for making the distinction between a benign and malignant lesion of the choroid or ciliary body is the radioactive phosphorus ^{32}P uptake test. Iris lesions have been excluded from this discussion because we have not found the ^{32}P test useful in identifying iris melanomas. A combination of factors accounts for this, including (1) the relatively small mass of iris lesions, and (2) the corneal thickness and the depth of the anterior chamber, which separate the iris lesion from the counting probe. We no longer do ^{32}P testing in patients with iris lesions.

Radioactive Phosphorus

Radioactive phosphorus is a colorless, odorless liquid isotope of phosphorus with a half life of 14 days. It emits beta particles. Actively metabolizing cells have been shown to incorporate phosphorus in their metabolic cycle, and thus with the passage of time ^{32}P will accumulate in such tissue. By utilizing

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the radioactive isotope of phosphorus, the clinician is afforded a means of measuring this accumulation, and comparing it with other, presumably normal, tissue. A high concentration of ^{32}P in a tissue often denotes the presence of a malignancy, but tissue such as healing surgical wounds, with granulation tissue, can also concentrate ^{32}P. Thomas[9] first described the use of ^{32}P in detecting ocular tumors, and Dunphy,[10] Carmichael,[11] Leopold,[12] and others have contributed to our knowledge of this diagnostic modality.

Clinical Experience

Since 1965, we have been using the ^{32}P test routinely in our evaluation of patients presenting with masses of the uveal tract. Initially, the test was performed as an ancillary adjunct in eyes which were to be enucleated anyway with a clinical diagnosis of malignant melanoma. It soon became apparent, however, that the test was uniformly positive in eyes which were shown pathologically to contain a malignancy. From these beginnings, we moved to utilize the ^{32}P test in cases where the diagnosis was not so obvious clinically, and we are now at the point where we consider it the single most helpful diagnostic test available in the differential diagnosis of a uveal mass. In our hands, a positive ^{32}P test is strong evidence pointing to the diagnosis of an ocular neoplasm. Likewise, a negative ^{32}P test is highly significant and good evidence against the existence of an ocular malignancy.

Certain refinements in the technique of performing the test have proved invaluable, especially for posteriorly placed lesions. We have utilized a conjunctival incision, mobilization of the globe with traction sutures under the muscles, and accurate localization of the tumor with indirect ophthalmoscopy, marking the sclera with diathermy so as to locate on the surface of the globe the exact position of the underlying choroidal tumor. The counting probe can then be positioned directly over the lesion and readings taken. Accurate and precise localization of the tumor cannot be stressed too strongly because the radioactive phosphorus is a beta emitter, and beta particles travel only a few millimeters in tissue. If the probe is not directly over the lesion, falsely low (false negative) readings may occur. We think that this probably occurred with small, posteriorly placed lesions when the conjunctiva was not incised in the early days of ^{32}P testing, and was one reason the test fell into disrepute.

Before describing our clinical experiences with ^{32}P testing, we shall outline how we evaluate a patient presenting with a choroidal tumor mass. A complete ophthalmic and medical history is taken with particular reference to any history of neoplasm elsewhere in the body. Such a patient receives a thorough eye examination, and the suspicious lesion is studied with indirect ophthalmoscopy, slit lamp contact lens examination, transillumination, contact B-scan ultrasonography, and fluorescein angiography. At this stage, the decision is made whether or not to do a ^{32}P test. We do not do the test, for instance, on lesions we think are nevi clinically, or on post-operative choroidal detachments. Obviously, this involves making a clinical judgment on the basis of what we see in the eye, and quite obviously this judgment is not infallible.

In the majority of cases of uveal masses, ^{32}P testing is done. The patient is admitted to the hospital, where a thorough medical evaluation is done by a qualified internist who knows that a tumor is suspected and who knows to look for a primary site of neoplasm, or evidence of distant metastases. Complete blood studies, including SMA 12, urinalysis, and chest X ray are routinely done. We have not done more extensive procedures such as GI series, barium enema or IVP as part of a routine work-up, as these have proved to be non-productive in the average case. However, if the history or physical findings indicate, then these tests are carried out.

Forty-eight hours after the intravenous injection of ^{32}P, the readings are made in the operating room. After localizing the lesion as described earlier, several readings are taken over the lesion, and at least three readings over each of the other three "control" quadrants in the same eye. We do not use the fellow eye to get our "control" readings. These results are then averaged, and utilized in the following formula:

$$\frac{{}^{c}L - {}^{c}N^{*}}{{}^{c}N} \times 100 = {}^{32}P \text{ uptake}$$

*^{c}L = Counts over lesion.
^{c}N = Counts over the normal quadrants.

We consider a 65 per cent ^{32}P uptake, or greater, a positive test. However, in the vast majority of patients with ocular malignancies, the ^{32}P is well over 100 per cent and frequently is in the range of 200 per cent to 300 per cent.

From January 1, 1965, through December 31, 1974, we have performed a total of 231 ^{32}P tests. The results are as follows:

TOTAL ^{32}P TESTS: 231

A. Positive Tests: 185
   (False Positive: 1)
B. Negative Tests: 46
   (No known false negative test)

Positive ^{32}P Test

Some 185 cases have had positive ^{32}P tests. Only one of these is known to be a false positive test. This

involved a lesion of the peripheral choroid in a 34-year-old Negro male in which the ^{32}P test was 122 per cent positive. The eye was removed and the lesion was diagnosed histologically as benign adenoma of the retinal pigment epithelium.

Of the remaining 184 cases, the histopathologic diagnosis is known in 161 cases, and in every single case the lesion was a neoplasm. In 23 instances we do not know the histopathology, either because the eye was not removed for one reason or another or because we have not been able to obtain the necessary information. In view of these statistics, we feel justified in stating that a positive ^{32}P test is very strong evidence indeed for the presence of an ocular malignancy.

As stressed earlier, most of the 156 cases of melanoma were easily diagnosable clinically, and the positive ^{32}P readings were not unexpected. Thus, one of the questions which we are frequently asked is, "how often has the ^{32}P test been *really* useful and told you something you didn't already know?" The answer to this is, "not often, but it does occur," and we feel the ^{32}P test should be an integral part of one's diagnostic armamentarium in diagnosing uveal masses. The following cases should help illustrate this point:

Case 1: Choroidal melanoma in a 14-year-old white female, correctly diagnosed with ^{32}P testing.

This 14-year-old white female presented with a choroidal mass lesion in the left eye. The vision in the eye was reduced to 20/50. The lesion was slightly elevated, moderately pigmented, and the superior edge of the lesion involved the macula. A ^{32}P test done at this time was positive, but because of the patient's age she was referred to another center for consultation. The consultant felt very strongly that the lesion was a benign disturbance of the retinal pigment epithelium and advised against enucleation. Six months later the lesion had enlarged in size and a serous retinal detachment had appeared. The ^{32}P test was repeated and again was markedly positive. The globe was removed, and the lesion was a Spindle B melanoma of the choroid.

Case 2: Malignant melanoma diagnosed by ^{32}P testing in a case being followed with a clinical diagnosis of choroidal hemangioma.

A 32-year-old white female was referred with a choroidal tumor mass in the right eye. This mass had first been discovered two years earlier and was associated with a serous secondary retinal detachment. The diagnosis of malignant melanoma was entertained and enucleation was scheduled. However, in the operating room, it was noted that the lesion in question blanched upon compression and that no transillumination defect was visible. These two factors gave the surgeon pause; enucleation was cancelled and the patient was referred for further consultation. Several experienced consultants saw the patient and diagnosed hemangioma of the choroid, and the patient was treated with photocoagulation and followed. However, in that time the lesion grew and the serous detachment did not disappear despite the photocoagulation treatment. When the ^{32}P test was performed, the test was markedly positive (142 per cent) and the eye was enucleated. Histopathologically, this lesion proved to be a Spindle B melanoma of the choroid.

The foregoing are instances where the ^{32}P test has been helpful to us in establishing the correct diagnosis in difficult and challenging cases where there was a legitimate difference of opinion between experienced and expert clinicians, and thus illustrates the diagnostic potential of this modality.

Metastatic Tumors

In five instances, we have enucleated eyes harboring choroidal tumor masses which were thought to be malignant melanomas clinically, only to learn from histopathologic examination that the lesion was a carcinoma metastatic to the choroid. In each of these cases, the patient was not known to have a tumor elsewhere, and the ocular metastasis was the first sign of the disease. These lesions were pigmented collar button tumors, indicating extension through Bruch's membrane, and fluoresced with intravenous fluorescein. All of these characteristics point toward a diagnosis of malignant melanoma. In addition, no primary tumor had been discovered in the preoperative medical evaluation. Indeed, in several instances a primary tumor could not be found despite very intensive medical evaluation once the lesion had been found to be a metastatic tumor. In these cases it was many months before the primary tumor, usually a bronchogenic carcinoma, became manifest.

Negative ^{32}P Test

In our series of cases, a total of 46 negative ^{32}P tests have been encountered. In none of these cases is histopathologic material available, and thus we cannot categorically state that the lesion in question is, in fact, benign. The clinical diagnoses made in these cases are listed in Table 1. These patients are being followed, however, and thus far no evidence of an ocular malignancy has appeared in any of them. We definitely feel that a negative ^{32}P test, if

TABLE 1

CLINICAL DIAGNOSES IN EYES WITH NEGATIVE ^{32}P TEST

Choroidal hemangioma	16
Choroidal nevus	5
Choroidal hematoma	5
Retinal cyst	5
Choroidal pseudotumor	2
Coats's disease	2
Choroidal detachment	2
Subpigment epithelial hemorrhage	1
Pigment epithelial detachment	1
Ectopic disciform detachment	1
Retinal detachment with Von Recklinghausen's disease	1
No diagnosis	5

correctly performed, is strong evidence against an ocular malignancy.

It is apparent that the most commonly encountered lesion giving a negative ^{32}P test is a choroidal hemangioma, and this constitutes an important disease entity. In many of these cases, prior to the ^{32}P testing, expert clinicians were undecided between the diagnosis of choroidal hemangioma or amelanotic melanoma on the basis of the clinical evaluation. We have found that the ^{32}P test is very useful in making this clinical distinction. Eyes containing choroidal hemangioma are salvageable if the diagnosis is made early, because photocoagulation is effective in clearing the serous detachment and re-establishing central visual acuity.

The next case illustrates the value of a negative ^{32}P test, since it averted an almost certain enucleation. The patient is a 58-year-old white female with a three-day history of redness and swelling about the left eye with some pain in the eye. She was referred when her local ophthalmologist found a large elevated choroidal mass at the inferonasal border of the optic nerve with a large secondary serous detachment of the retina. The lesion was thought by most observers to be a malignant melanoma of the choroid. A ^{32}P test, however, was negative, and because of this the eye was not enucleated. The patient was treated with subtenons steroid injection. Over the course of the next few weeks the tumefaction subsided and the serous retinal detachment disappeared. In follow-up over the next 18 months, the patient has been found to have a widespread disturbance of the retinal pigment epithelium, but the choroidal tumor mass is gone and no serous detachment of the retina has reappeared.

Summary

In summary, we have utilized the ^{32}P test in evaluating a total of 231 cases of mass lesions involving the choroid. We feel that this test offers the best means available for differentiating benign from malignant tumors of the choroid. In our experience, false positive and false negative test results are rare. Therefore, a positive test is strong evidence that the eye contains a malignancy, while a negative ^{32}P test is strong evidence against the presence of an ocular neoplasm. ■

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This condition has not been reported previously in twins.

Cor Biloculare. Report of Congenital Heart Disease in Twins

KENNETH ALONSO, M.D. *and* JOSEPH M. DEW, M.D., *Riverdale**

Cor biloculare represents the most primitive type of heart encountered. The malformation is quite uncommon. Four such hearts have been described in 25 years of postmortem examinations at Fitzsimons Army Medical Center—a reported incidence of .05 per cent.[1] Rothmaler collected 40 cases from the world's literature between 1958 and 1968, and added two cases of his own.[2] Few cases have been added since.[3–5] This report discusses our latest encounter with cor biloculare: congenital heart disease in twins with and without asplenia, with an unusually long survival of the twin with cor biloculare.

Case Report

DLC was the 2.75 kg last born product of an identical twin pregnancy of 10 months gestation. She presented as a difficult footling breech and was thought to be dead at birth because of her extreme flaccidity. Her twin sister was cyanotic and icteric, expiring one month after birth with multiple congenital anomalies. There was no parental history of disease.

At one month of age it was noted DLC would become cyanotic with crying. The cyanotic episodes progressed in frequency and became more pronounced. Upper respiratory infections were a recurrent problem. Hospitalization at age 11 months disclosed a cyanotic female infant not obviously ill with height (71.1 cm) and weight (7.6 kg) in the third percentile for age. A loud systolic murmur best heard at the third left intercostal space at the sternum was described. P_2 was muffled. No other abnormalities were noted. Admission chest X rays were unrevealing. Electrocardiograms obtained at this time were compatible with right ventricular preponderance. A barium swallow with PA, lateral, and oblique chest X rays demonstrated only ventricular enlargement. It was elected to observe DLC over a period of years.

Cardiac catheterization with concomitant biplane angiography at age 2½ years revealed a right aortic arch with minimal anterior displacement of the aortic root. Pulmonary infundibular stenosis was identified. A large communication was thought to be present between atria and also between ventricles. A right-to-left shunt greater than 25 per cent of total systemic flow was demonstrated. Elevated right ventricular pressure was discovered (Table 1). A left superior vena cava was seen. The procedure was terminated because of persistent ventricular arrythmias. DLC was discharged with no specific therapy instituted.

Because of increasing symptomatology, a Blalock-Taussig procedure was performed for palliation in 1968 at 10 years of age.

Echocardiography late in the course of life confirmed the presence of a single ventricle with a common atrioventricular valve. Physical examination demonstrated persistent cyanosis with clubbing. Peripheral blood smears continued to demonstrate no

TABLE 1
CARDIAC CATHETERIZATION AGE 2½ YEARS

Source	Oxygen Saturation %	Pressure
Femoral vein	65	
Left subclavian vein	56	
Superior vena cava (right)	59	
Right atrium (at coronary sinus)	58	22/10mmHg
Right atrium (at AV valve)	71	22/10mmHg
Right ventricle	71	95/0 to 122/2mmHg
Left atrium	77	22/10mmHg
Left ventricle	71	95/0 to 122/2mmHg

* Dr. Alonso can be contacted at Clayton General Hospital, P.O. Box 328, Riverdale, Ga. 30274, and Dr. Dew is with the Department of Pathology at Ireland Army Hospital, Ft. Knox, Ky. 40121.

Howell-Jolly bodies in erythrocytes. Her remaining post-surgical course was one of intermittent cardiac failure. She was supported with glycosides, diuretics, and antibiotics over her last three years of life. Multiple admissions were directed at alleviating her profound cardiac failure. DLC expired at home at 13 years of age.

Family History

The first born identical twin sister of DLC expired at one month of age with cardiac failure following abdominal surgery with bypass of an obstructing duodenal lesion. Postmortem examination demonstrated total situs inversus, dextrocardia, a right sided aortic arch, transposition of the great arteries, inversion of the ventricles with a rudimentary left sided ventricle present, and drainage of the caval venous systems into the left sided atrium. A spleen was found. A membrane extended across the lumen of the duodenum immediately proximal to the ampulla of Vater.

Postmortem Findings

The heart was grossly enlarged with a blunted apex. The aorta was anterior to the pulmonary artery; the arch was to the right of the trachea. A left subclavian artery-left pulmonary artery anastomosis was present and patent. A ductus arteriosus was not found. The left superior vena cava was present and terminated in the superior aspect of the left portion of a common atrium. Also communicating was a blind pouch representing the coronary sinus. The (right) superior vena cava terminated in the superior aspect of the right portion of the common atrium; the inferior vena cava, into the inferior aspect of the right portion of the common atrium.

The atrial appendages mirrored each other. A single 22 x 5 x 5 mm strand of fibrous tissue bridged the anterior and posterior walls of the common atrium above a five leaflet common atrioventricular valve (Figure 1). Five large papillary muscles with chordae supported valve leaflets. A single ventricle, morphologically the right ventricle, was identified (Figure 2). The pulmonic valve was bicuspid, fibrotic, and measured 0.5 cm^2. The aortic valve had three pliable cusps. The pulmonic and aortic valves were separated from the common atrioventricular valve by subaortic and subpulmonary conal muscu-



FIGURE 1

View down into the right side of the common atrium demonstrating the strand of fibrous tissue bridging the common atrium above the common atrioventricular valve.



FIGURE 2

View of the single ventricle. The aorta overlies the common atrioventricular valve. The small pulmonary artery lies posterior to the aorta. A probe is placed in the pulmonary outflow tract.

lature. The coronary arteries arose and were distributed normally.

The left lung was divided into three lobes as was the right. The bowel was situated normally. No spleen was found. No splenic remnants were demonstrated microscopically.

Comment

The absence of proper septation of the common atrium and ventricle—bulbus cordis—is rare. However, malformations of this type are the most commonly described cardiac abnormalities associated with splenic agenesis.[6]

The splenic primordia appear in the dorsal mesogastrium of the human embryo at the fifth week. At this period septation of the bulbus cordis, intestinal rotation, and branching of the bronchial buds to form larger conductive tubules is also proceeding.[7] Interruption of development at the fifth week of embryologic life, then, is associated with a constellation of abnormalities in these organ systems. The presence of such anomalies in monozygotic twins, one of whom possessed a spleen, has not, to our knowledge, been reported previously. No known etiology has been described.

The prognosis in cor biloculare is generally poor, most patients surviving less than one year. Few long term survivors have been recorded.[8-11] At present there is no correctible surgical approach. ■

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NEUROLOGY BECOMES SEPARATE DEPARTMENT AT EMORY

Neurology has been established as a separate department in the Emory University School of Medicine, Dean Arthur P. Richardson announced. Formerly a division in the Department of Medicine, the Department of Neurology will continue to be headed by Dr. Herbert R. Karp who was named professor and chairman of the new department. Dean Richardson said the Department of Neurology was established on recommendation of the Faculty Advisory Council of the School of Medicine.

Neurology was initially established as a division in the Department of Medicine in 1958 under Dr. Karp's direction. An Atlanta native, Dr. Karp has the A.B. and M.D. degrees from Emory and took postdoctoral training in neurology at Duke and Harvard. One of his research interests is the diagnosis and treatment of strokes, and he is currently involved in a study of stroke in rural Georgia with particular emphasis on determining factors which predispose the patient to develop a stroke.

Four MAG proposals designed to ameliorate the potentially dangerous situation in Georgia are reviewed.

Professional Liability Problems Have Reached Georgia

JAMES A. KAUFMANN, M.D., *Atlanta**

MANY GEORGIA PHYSICIANS have been lulled into a false sense of security regarding malpractice insurance because rates in Georgia have not yet escalated to the astronomical heights that have plagued physicians and patients in other areas.

There are two immediate reasons for concern:

First, Georgia has gone to a claims-made type of coverage. As cited in the *Journal of Legal Medicine,*[1] this form is a "snare and a delusion" because the true cost is far less in the first year due to the fact that many claims will not appear, having been covered by a previously carried occurrence policy. Claims-made type coverage ends with the expiration of the policy, making it necessary for a physician to carry an additional tail policy to protect him and his estate against potential financial disaster. Under current law, claims can be made for practically an indefinite period. If he is unfortunate enough to move to another state he will have to carry malpractice insurance in both states.

Secondly, a survey done by the author of attorneys in Georgia indicates a vast increase in the number of inquiries from clients in regard to possible malpractice suits. This increase is a direct result of the vast national publicity focused on this problem.

It is apparent, therefore, that professional liability rates in Georgia will become intolerable to both patient and physician in the next two or three years unless something is done—soothing words from insurance carriers notwithstanding.

Side Effects

What is not apparent are some of the inevitable side effects of the increasing rates, such as what has happened in our neighboring state of Kentucky. There it costs a well-trained obstetrician an initial premium of more than $20,000 per year to enter practice before he has seen his first patient. Obviously, in this type situation young physicians will tend to avoid entering private practice in the areas where they are needed most in favor of entering established groups and clinics. Experienced physicians who are limiting their practice could not continue economically to practice under this type rate structure.

There have been many solutions proposed for this tragic situation. Some of the cures, however, are worse than the disease. For example, proposed federal statutes tend to substitute legal aid for independent legal representation, government insurance for private carriers, to federalize medical care and to limit the recovery of patients.

Having read all the statutes proposed or enacted in each of the states, the author personally feels the proposals set forth by our insurance committee under the leadership of William W. Moore, M.D. of Atlanta are both reasonable and sensible and will be effective in relieving this potential disaster.

I also want to be absolutely certain that our motives in submitting these proposals are clearly understood. It is not our desire to limit the right of any person who has been injured by a physician to pursue his just claim, nor to disrupt the legal system which has served us so well. In fact, we are hopeful and desirous of having the support of the Georgia Bar Association and the Georgia Trial Lawyers Association for these proposals.

Statute of Limitations

Our first, and most important, proposal is to establish reasonable, just rules of discovery that would not toll the statute of limitations for indeterminable periods. A statute such as that of Delaware might serve as a model. The Delaware law provides that the statute of limitations begins to run when "the

* Chairman of the State Legislative Committee, MAG, Dr. Kaufmann is an internist in practice at 950 W. Peachtree St., N.W., Atlanta, Ga. 30309.

harmful effect first manifests itself and becomes physically ascertainable."[2] A person would have two years following that date to bring action.

The effect of this would be to protect against suits brought many years after the alleged occurrence which are difficult to defend because of the lapse of time. It is also virtually impossible to determine actuarially the insurance premium to be charged to protect against a suit filed many years in the future.

Suing for Exaggerated Sums

The second proposal is the removal of the *ad damnum* clause in pleadings. This is the most abused feature of tort litigations. It permits a claimant to sue for exaggerated sums far in excess of the true value of the claim simply to attract publicity and coerce defendants into settling in order to avoid this adverse publicity. An additional harmful effect of this clause is that the publicity often leads the public to believe this is the actual amount of the award or settlement, generating additional exaggerated or nuisance claims.

From our interviews, we have found that many attorneys feel that a case is not materially affected by this dollar allegation because the actual damages can be made abundantly clear to a jury during the trial. We feel most responsible lawyers would be agreeable to the elimination of this wanton damaging of reputations.

Some have blamed the news media for the publicity. However, a person of prominence being sued for millions of dollars is newsworthy, and the media are entirely justified in covering the case. We certainly shun any proposal that would limit, in any way, the right of the media to cover anything that occurs in a malpractice proceeding. The elimination of the *ad damnum* clause would only eliminate the inflamatory and sometimes vicious use of dollar claims. It is our understanding that this proposal has the endorsement of the State Bar of Georgia.

Collateral Payment Sources

Our third proposal is that the jury in a malpractice action be informed of all the plaintiff's collateral sources of payment for the same incident. The jury would not be required to delete these amounts; however, we feel this information would be of assistance to the jury in reaching a just verdict.

Binding Arbitration Panel

Our final proposal would be a voluntary binding arbitration panel consisting of one physician appointed by the plaintiff, one appointed by the defendant, a third agreed upon by both parties and a non-voting attorney as chairman. Hopefully, this would be helpful in disposing of smaller cases without the time-consuming expense of legal proceedings. Arbitration is already permissible under Georgia law, but the creation of an established form would encourage its use.

The above are legislative proposals. Important as they are, we must be aware that all relief cannot come from the legislature. There are certain things we can do for ourselves.

Several national medical and legal publications have proposed a system whereby a weekly bulletin would be issued to all physicians alerting them of drugs, procedures and techniques that have led to malpractice claims. In reviewing these publications, I feel that such a system would be helpful to us in Georgia. This would be a system in which our medical societies could participate with other groups both locally and nationally to assist in avoiding recurring pitfalls.

Medical Jurisprudence

Having reviewed many alleged claims of malpractice, the author also has discovered that many suits arise from technical ignorance of the law on the part of physicians rather than from improper medical practice. It is sad to note that at a time when physicians need it the most, medical schools have abandoned courses in medical jurisprudence. I feel that claims against physicians and hospitals could be greatly reduced if the insurance carriers would provide a course in medical jurisprudence. A physician successfully completing the course should receive a 20 per cent reduction in his professional liability insurance rates, just as high school students currently receive through the drivers education course. I feel the insurance carriers would save even more.

I further feel that we need additional insurance carriers writing malpractice insurance in this state. Legislation has been passed enabling the insurance commissioner to carry this out and Commissioner Johnny Caldwell is most interested in the problem. It would be useful to pursue this matter with him, as nothing stimulates the free enterprise system better than competition.

A number of physicians have devoted long hours to this problem and to these proposals, but we need the active work of every physician in this state to prevent this problem from reaching crisis proportions. Few realize the amount of work Mr. Rusty Kidd has put into the legislative aspects of our situation, or his dedicated interest. I urge all physicians to keep in contact with Mr. Kidd or your state legislative committee chairman concerning these matters. We are available day or night.

After you have become properly informed on the subject, it is essential that you contact your legislators for the continued discussion of this problem. They must know the extent of the problem and your views of it. We cannot do it alone.

We owe it to our patients and to our profession to do all possible to see that the problem of malpractice insurance does not cripple the medical services available in Georgia. ■

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"I'm writing you to praise a doctor . . ."

The following letter praising an Atlanta area physician for his care and concern was sent to David A. Wells, M.D., president of the MAG at the Headquarters Office. It is reprinted, with the physician's name omitted, as an interesting example of how one member of the public views the actions of the medical profession.

Dear Dr. Wells:

I am sure as President of the Medical Association of Georgia you receive many complaints about various doctors. Let me assure you I could add several names to that list. However, I am writing you to praise a doctor not to complain about one. My reasoning is as follows:

For five years I had a problem called a cracking scapula. As this ailment continued to worsen, I consulted several doctors. Each time I was treated with what I term lack of treatment and told to come back in a couple of months if it wasn't better. Having had this problem for over five years and felt the condition worsen each year, I knew time was not the cure.

My mother by this time had been injured at work and suggested I visit her doctor, whom she held in very high regard. I am pleased to say I did. After evaluating my condition and consulting other doctors, Dr. ——— told me he would have to operate. Being a 22-year-old man, I knew I should not fear an operation, but I did. The day before the operation, Dr. ——— sensed my fear and sat my girl friend (who is studying to become a nurse) and I down and explained the whole procedure to us. He explained how, what and why he was going to do during the operation. After the operation he or one of his staff were in daily communication to see how I was doing.

When I was operated on, Blue Cross and Blue Shield told my parents and I that I was covered. Yet when the bill came, they explained they were mistaken and that I wasn't covered *at all.* There I sat with a $1,000 hospital bill and a $400 doctor's bill. I informed Dr. ——— of this and it would be quite some time before I could pay him; especially since my mother was disabled and my stepfather is retired. Being a full-time student, I did not have the resources to turn to either.

After hearing this, Dr. ——— said, "Mike, don't worry about it, my family has food in their mouths and a roof over their heads, so you can pay me whenever you can." He even jokingly offered a deal by saying, "When you become a successful politician, I'll just triple your bill and send it to you." You can imagine what a burden this has lifted from my shoulders. Most importantly, it renewed by faith that for every bad doctor out there, there is a Dr. ——— to make up for him.

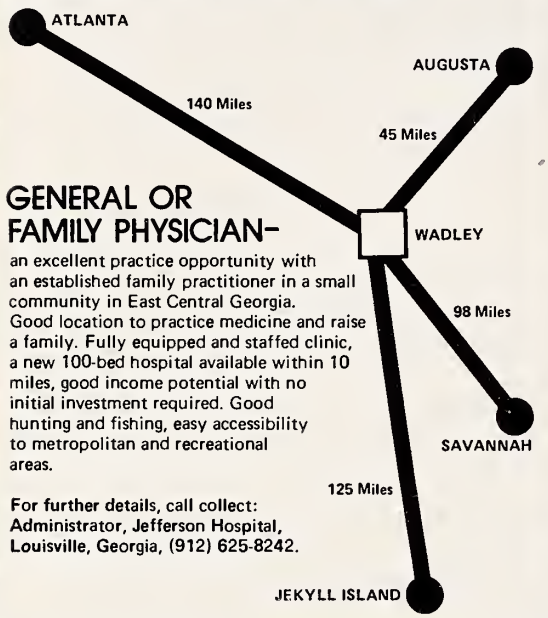
My entire family loves Dr. ——— and we all consider him and his staff family.

To show how great a surgeon he is, he told me I would be able to make a left-handed layup in basketball in at least six weeks. Well, in three weeks I was playing and coaching, leading my fraternity basketball team to an unprecedented All-University title. Since then I have won the Interfraternity tennis title and Interfraternity racquetball doubles championship.

My purpose for writing you was to inform you of this fine man. Also, if there is any award which your Association might have I would like to nominate Dr. ——— and staff for that award.

Sincerely,
Mike Sloane
Atlanta

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Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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The AMA 1976 Dues Structure—Some Questions and Answers

During the June 1975 meeting of the AMA House of Delegates, a dues increase was approved raising the figure for regular members from $110 to $250. The following fact sheet is designed to answer some of your questions on the dues increase: the financial problems that necessitated it; how costs have been cut by the AMA; and the budgeting plans made for future programs necessary if the AMA is to avoid becoming a static organization.

Why did the AMA increase its dues?

The AMA was caught in an economic squeeze—the same kind of squeeze that nearly every individual, business, and organization has been faced with in recent years. Costs have risen. The AMA revenues have become inadequate to meet operating expenses. *The Association has operated at a deficit four of the past five years and reserves are insufficient to cover additional deficits.*

How long has it been since the last dues increase?

AMA dues have not increased since 1971, but operating costs have soared.

Was the membership alerted to the possibility of a dues increase?

Yes. In November, 1974 members of the AMA's House of Delegates, state medical associations, and medical speciality societies were notified of the existence of a "critical financial situation" and subsequently received additional background information on a proposed dues increase, the 1975 budget, a projection showing the effect of a proposed dues increase for 1975 to 1980, and reports on various aspects of the financial problem submitted by the Boar of Trustees.

The general membership was informed by articles in *AM News* and the *AMA Newsletter*.

During the 1974 Clinical Convention the House of Delegates created a Special Committee of the House to review the priorities and financial capabilities of the organization with a report requested during the 1975 Annual Convention.

Did the membership have an opportunity to present its views during the deliberations on the dues increase?

Yes. Each segment of the profession—general members, representative members, elected leaders, federation components, allied medical organizations, and staff—was afforded an opportunity to contribute to the review process and to the special committee's deliberations.

What caused the financial problems identified in late 1974?

The financial problems were primarily due to:

1. Inadequate dues structure to support activities.
2. Marked reduction in cash reserves due to cumulative effects of deficit spending.
3. Overprojection of anticipated advertising revenues compared to income.
4. Acute cash flow deficiency in October and November of 1974 attributable to:
   a. Conversion of cash reserves into capital investments and fixed assets
   b. Adverse effects of simultaneously occurring inflation and recession
   c. Continued high expenditures for publications due to long lead time to effect reductions
   d. Customary end of year reductions in income.

What has the AMA done to cut cost?

Staff has been cut back by over 200 employees and publications cost have been reduced by 20 per cent. "A zero based" budget has been implemented which requires periodic rejustification of expenditures for every AMA activity.

Despite imposition of stringent financial constraints, expenditures continue to exceed income from all sources exclusive of income from the assessment instituted in 1975.

How has the AMA used the money received from the special assessment?

The money generated from the assessment was used to repay short term bank loans of $3.0 million, for reserves for the projected $2.6 million 1975 deficit, and to reduce accounts payable by $1.3 million.

What will the dues increase mean to the AMA?

The dues increase will currently assure a fiscally stable organization capable of aggressive action.

The dues increase will enable the AMA to:

DUES / Continued

1. Continue activities at the present dollar level;
2. Reexamine priorities and, depending on such review, restore some programs and initiate new ones to the extent of $2 million per year for the next few years;
3. Achieve a reserve fund of liquid assets equal to the 60 per cent of annual operating expenses within two years.

Why is there a need for liquidity reserves?

It is urgent that the AMA's liquidity reserves be expanded quickly and substantially. The Board of Trustees and the AMA auditors are agreed that the Association's minimal liquidity reserves should be equal to 60 per cent of its annual operating expenses. The establishment of a fund adequate to cover unforeseeable operating expenses and abnormal contingencies is a sound business practice.

Why is the AMA considering new activities when they should be discontinuing programs in order to cut costs.

Both the House of Delegates and the membership at large have indicated that they do not want the AMA to become a static organization. The vote in the House to increase the dues showed that members of the House of Delegates want a strong, vigorous, financially healthy AMA. Therefore, the Board has included in its projections an additional $1 million per year for newly budgeted programs.

Will the dues increase cover the cost of high priority but unbudgetable activities?

Yes. The Board has added $1 million per year to operate the many high priority but unbudgetable activities, such as those that require legal action or sudden legislative effort, that must be conducted by the AMA if it is to remain in a leadership position. Governmental intervention through the use of rules-writing powers has grown at a rapid pace during the 1970-75 period, and the membership's rising demand for legal action is justified. The AMA went to court earlier this year and filed suit against HEW to prevent implementation of the UR regulation. In August, HEW said it will withdraw its UR regulations and will propose new language to replace the rules. The AMA is now in court against another set of regulations and one other law suit against federal regulations is now pending. The cost of these three law suits alone may total about $500,000.

How much of the AMA's budget goes to support the AMA's lobbying effort?

The AMA is primarily a scientific orgnization. Despite the public media's attention to legislative activities, over 54 per cent of AMA's budget is spent to improve the delivery of medical and health care; 12 per cent to improve the quality of American medicine; 11 per cent to improve the public's health knowledge and practices. Only about one-half of 1 per cent is allocated to the Department of Congressional Relations (our lobbyists). ■

IMPORTANT NOTICE FOR PHYSICIAN'S RECOGNITION AWARD APPLICANTS

Printed in the August, 1975, issue of the *Journal* was a yellow form for the physician to keep an ongoing record of his or her continuing education. This form may be used *as the physician's application* for the AMA's Physician's Recognition Award. However, since the printing of the form there has been a change in the AMA's policy on the application fee for the award. Beginning January 1, 1976, AMA members will *not* be required to pay an application fee, whereas the fee for non-members of the AMA will be increased to $25.00. Additional copies of the form are available from MAG on request.

State Action Delays CHEC Program Implementation

ON OCTOBER 5, 1975, the Georgia Medical Care Foundation was notified by the Director of the Medicaid program of the State's intention to terminate the contract with the Foundation for implementation of the CHEC program for Georgia Medicaid patients. This decision, based upon short-run monetary considerations and a poor understanding of the functioning of a concurrent hospital review program, is an unfortunate one, and certainly not in the best interest of the patients, the physicians or the hospitals of the State of Georgia.

As has been reported to you from time to time in this **Journal,** the Certified Hospital Extension of Care, or CHEC, program has been sponsored by the Medical Association of Georgia, and its Foundation, in an attempt to provide the physician of Georgia with a reasonable and medically sound means of complying with utilization review regulations of November 29, 1974. Work on this program had gone on for nearly two years at the time these regulations were issued, and the program at that point did not include what we have come to know as the 24 hour admission review component. When the regulations were issued on November 29, the requirement for 24 hour admission review was included and appropriate modifications made to the CHEC program. When AMA was successful in enjoining this aspect of the regulations, your Foundation undertook to withdraw this requirement from the CHEC program in accordance with Judge Hoffman's ruling. The administration of the Medicaid program, however, saw things differently. In an effort to work out the differences between the program, as the Foundation offered it, and the apparent requirements of the Department of Human Resources, a meeting was held to seek an equitable alternative to the 24 hour review admission requirement. In response to the requirements outlined by the Department of Human Resources at this time, the Foundation prepared and forwarded to the Medicaid program a proposal which was felt to be both acceptable to the physicians of the State of Georgia and functional in design. Some 10 days later, representatives of the Medicaid program informed officers of the Foundation that the state had adopted an either/or position, that being that either the CHEC would contain a 24 hour admission review requirement as outlined in the regulations or there would not be a CHEC program for the Medicaid patients this year. When the Attorney General advised the Medicaid program of its potential liability by requiring the limitation of a review program with a 24 hour admission requirement, the decision was made to terminate the CHEC contract.

It is a shame that the administrators of the Medicaid program felt compelled to adopt the attitude that they did. The CHEC program represented a voluntary effort on the part of organized medicine to assure the people of the State of Georgia that Medicaid recipients were receiving the medical care they deserved, in the appropriate manner, and with the best possible utilization of the resources available at this time, and as such was a significant

landmark in the history of peer review in Georgia. While this decision on the part of the State dealt the CHEC program a strong blow, the program is not over, but it is delayed considerably and the burden of this delay will be on the patients and the taxpayers of the State of Georgia.

Earnest C. Atkins, M.D.
President, Board of Directors
Georgia Medical Care Foundation

GEORGIA PHYSICIANS URGED TO UTILIZE COMPUTER PROGRAM FOR EVALUATION OF ELECTROLYTE AND ACID-BASE DISORDERS

With the support of the Georgia Regional Medical Program, the Emory University School of Medicine is beginning the second year of a project to test the clinical feasibility of using a computer program for evaluation of electrolyte and acid-base disorders. The computer program was designed in 1969 by Dr. Howard Bleich, formerly a resident at Grady Memorial Hospital, now associate professor of medicine at Harvard Medical School and Beth Israel Hospital in Boston. This program has been in daily use in a number of hospitals in New England for the past three years. It was introduced to Georgia physicians in August 1974 under the direction of Dr. W. Dallas Hall and Dr. Elbert P. Tuttle, Jr. of the Division of Nephrology and Department of Medicine of the Emory University School of Medicine. The program, entitled "Computerized Consultation Services for Disturbances in Electrolytes and Acid-Base Balance," is intended to assist in patient care decisions. It is in no way intended to substitute for individual physician judgment.

In the current year of the project the main emphasis will be on acquainting all practicing physicians in the state of Georgia with the program and with the benefits it offers to both them and their patients in the difficult area of electrolyte and acid-base abnormalities. The program was written to assist mainly with differential diagnosis and therapy for selected electrolyte disorders such as acidosis, alkalosis, hyponatremia, hypernatremia, hypokalemia and hyperkalemia. These problems are particularly common in general practice, surgery, pediatrics and internal medicine. The program does not currently know how to handle problems of hypercalcemia, acute tubular necrosis or oxygenation. More specific information about the program can be found in an article written by Dr. Bleich in the *Journal of Clinical Investigation* (48:1689-1696, 1969).

The use of the program is very straight forward and demands only a minimal amount of the physician's time. A collect call to (404) 659-2421, Monday through Friday from 8 to 12 a.m., 1 to 4 p.m., connects the physician with Ms. Missy Jamison, data processing assistant, who will ask for patient data such as electrolytes, blood sugar, BUN, creatinine, patient weight, and evidence of dehydration. The program might also ask for such values as chest X ray, urine output, blood pH or pCO2. All these values are not needed for the program to run, but the output will be more specific when they are available. These values are typed in as the physician, or his assistant, gives them on the phone. A consult is then rapidly generated, read to the physician and mailed to him on the same day. Total telephone contact time averages eight to 12 minutes.

Information about the program will be mailed out to Georgia physicians in the near future. Visits by Dr. Dallas Hall are planned to the communities in the state which show a strong interest. It is hoped that physicians will make use of the availability of the program.

Carcinoma of the Bile Duct

ROBERT W. JOHNSON, M.D. *and* CHARLES H. WRAY, M.D., *Augusta**

PRIMARY CARCINOMA of the biliary tree is an uncommon disease which presents a significant challenge for diagnosis and an even more difficult therapeutic dilemma. Specialized diagnostic techniques, including percutaneous cholangiography, liver scanning, arteriography, venography, and inferior vena cavography, must be instituted to afford a complete evaluation of the tumor pre-operatively. This disease is encountered in one of every 150 biliary tract operations and therefore becomes an important consideration in the differential diagnosis of the etiology of obstructive jaundice.

Cholangiocarcinomas are primarily adenocarcinomas with fewer papillary adenocarcinomas occurring though sarcomas and squamous epitheliomas have been reported. This disease usually involves the entire ductal wall with the major symptomatology being caused by ductal obstruction. Bile duct carcinoma is associated with sclerosing cholangitis and this diagnosis should be entertained in those patients who have jaundice and ulcerative colitis. Sclerosing cholangitis usually involves only the submucosa of the duct over extended lengths, though differentiation of these two diseases may be quite difficult due to the similarity in hepatic pathology proximal to the lesion. There is still some confusion concerning the real existence of primary sclerosing cholangitis without an occult cholangiocarcinoma. Cholangiocarcinoma has a strong association with calculus disease of the biliary tree.

The majority of tumors occur in the common duct, with contiguous spread and lymphatic metastases being the rule. Clinical findings are indicative of intermittent biliary obstruction. Epigastric pain is present in 50 to 60 per cent of patients and there is a rapid associated weight loss with pruritus. Most patients have palpable, smooth, tender livers with a palpable gallbladder being present in one-third of the patients. Serum bilirubin is usually in the 20 to 30 milligrams per cent range, exhibiting a characteristic fluctuation. Alkaline phosphatase is elevated and distinctive serum globulin elevations may occur. Liver biopsy may be misleading, as biliary cirrhosis may be a sequel to distal, mechanical, ductal obstructions.

The specialized diagnostic techniques mentioned have an important place in the determination of the resectability and/or progression of this disease. The percutaneous cholangiogram allows visualization of the lesion and ductal anatomy. The use of this technique alone is accurate in the diagnosis of over 80 per cent of patients and in combination with selective celiac arteriography, sensitivity is greatly increased. Cholangiomas exhibit less hypervascularity and hepatic arterial displacement than do metastases or hepatomas. Biliary carcinomas tend not to invade veins as exhibited by hepatic venography, or the vena cava as exhibited by inferior vena cavography. Hepatic scans are less helpful, but a combination of these studies al-

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lows reasonable interpretation of a lesion in an area where even direct vision at laparotomy may not be adequate.

Utilizing the above parameters, one may plan radical resection for cure or biliary diversion for palliation. Diversion may be accomplished with T or T-Y tubes, or appropriate anastomoses of the proximal biliary tree to the GI tract. Palliation may also be afforded by hepatic devascularization, by direct arterial infusion of chemotherapeutic agents, or radiation therapy. Quattlebaum, Quattlebaum, Cady and Fortner present cases which support the thesis that aggressive surgical resection, biliary diversion, and even multiple resections may improve the duration and the quality of life in patients with cholangiocarcinoma. In general, the more proximal the lesion, the more complicated the procedure, and the lesser the possibility of cure of the disease. Recent understanding of hepatic anatomy and physiology allow successful controlled hepatic resection with temporary circulatory isolation of the liver. Selective devascularization is now possible with an acceptable morbidity. Palliation with orally administered chemotherapeutic agents such as 5 FU has been of limited value, though direct infusion of such substances into the duct or into the hepatic artery may be of more promise. A recent patient at this institution survived 10 years, utilizing a combination of the above therapeutic modalities.

In summary, one must consider cholangiocarcinoma as an etiological factor in the differential diagnosis of obstructive jaundice. Those specific diagnostics discussed afford the surgeon a precise diagnosis and a foundation upon which to base a reasonable therapy. The relatively slow growth and low-grade malignant potentials of some cholangiocarcinomas should be recognized. Aggressive resection, then palliation by those methods discussed are the treatments of choice at the present time. ■

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Unstable Angina— When Is It Preinfarction?

Arthur J. Merrill, Jr., M.D., *Atlanta**

THE TWIN SPECTERS of sudden death and myocardial infarction have caused several centers to advocate emergency aortocoronary bypass surgery as treatment for all patients with worsening angina.[1, 2] However, a study of the natural history of unstable anginal syndromes suggests that such patients can be divided into high and low risk groups. Follow-up studies of patients treated medically have shown that many patients respond well to therapy. Other patients may well need consideration for urgent bypass surgery.

Unstable angina is best defined as any change in anginal symptoms. It may appear in any one of four clinical syndromes:

1. New onset angina;
2. Exacerbation or recurrence of angina in a patient with a previous history of infarction or angina (often presenting as a crescendo pattern);
3. Onset of angina at rest, following meals, or at night (angina decubitus);
4. Prolonged anginal pain, usually lasting longer than 15 minutes and unresponsive to nitroglycerine but without the electrocardiographic or enzyme changes of infarction.

Differing Prognoses

Each of these syndromes has a different prognosis. In a recent study, 3 per cent of patients with new angina died and 15 per cent had an infarction in the first year after onset.[3] The reported mortality in patients with recurrence or exacerbation of angina has been as high as 32 per cent in three months,[4] to as low as 8 per cent in two years.[5] The reported rate of infarction has varied widely in this group from 49 per cent within three months[6] to a low of 16 per cent in two years.[5]

Patients with ischemic heart disease who have the onset of rest angina have been reported to have a 50 per cent mortality in 2.5 years; within 6 months of onset of rest angina, 50 per cent will suffer an infarction.[7] Episodic prolonged pain, the most frequently studied form of "preinfarction" or unstable angina, accounts for 10-20 per cent of coronary care unit admissions and has a reported mortality varying from 23 per cent in 3 months[6] to 14 per cent in one year,[8] and an infarction rate varying from 42 per cent to 17 per cent. Gazes et al. reported that patients with new onset angina decubitus with persistent pain more than 48 hours after hospital admission have a mortality of 26 per cent in three months.[9] Thus mortality in unstable angina may vary markedly depending on the patients' clinical presentation and treatment. A change in anginal symptoms, persistence of symptoms in

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Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

spite of hospitalization and treatment is associated with high risk of subsequent infarction and death.

In almost all of the above studies the patients were treated only with bedrest, nitroglycerine prn and usually anticoagulants. The studies on anticoagulants in unstable angina have generally shown a favorable effect but have had no randomized controls. Few studies of "vigorous" multifaceted treatment of unstable angina have been reported. However, one such study by Hughes et al.[5] reported a 14 per cent mortality and 27 per cent incidence of infarction after *two* years, even though all patients had had previous infarctions and half had cardiomegaly. These patients were treated with anticoagulants, high doses of oral nitrates, progressive exercise, and monamine oxidase inhibitors if needed (these agents were used because Inderal was not available). All patients were told to stop smoking and any hypertension was controlled. Paul Wood also reported a mortality of only 6 per cent in a group of patients he treated and anticoagulated.[10]

None of the patients in the above studies had coronary angiography—a significant shortcoming since 20 per cent of patients with prolonged pain have been found to have normal coronary arteriograms. In a study of 35 patients with a change in their anginal symptoms within three months of angiography, we found that 18 per cent had normal coronary arteriograms. Twenty-four patients with abnormal coronary arteriograms were followed for an average of 43.6 months with a one year mortality of 8 per cent. All deaths occurred more than three months after angiography. Bertolasi et al.[11] have reported a one year mortality of 35 per cent in 20 patients with recurrent prolonged pain but only 5 per cent mortality at one year in 20 patients with "progressive angina."

All these patients had coronary arteriograms and abnormal coronary anatomy. These results also suggest that certain groups of patients may be controlled and improved by medical therapy. On the other hand, it appears that patients who continue to have pain during medical treatment have a high risk of infarction or death.

Vigorous Medical Therapy

What is vigorous medical therapy? Drs. Reeves and Harrison describe it well in their book, *Principles and Problems of Ischemic Heart Disease*. It can only be summarized here. All patients receive long-acting nitrates, as frequently as every two hours and in as large a dose as necessary to prevent ischemic pain. If needed, beta blockers are used to prevent anxiety or tachycardia-induced angina. A diary of time of meals, activity and pain occurrence is kept by the patient and used to regulate the frequency and dosage of nitrates and beta blockers. If pain occurs within two hours of nitrates, more nitrates are given; if pain occurs 2-4 hours after nitrates, they are given more frequently. A progressive exercise program is begun once an infarction is ruled out. Initially, the exercise level is set far below the patients' estimated physical capacity and gradually increased. Since this allows the patient to progress daily, he feels he is improving—a very important psychological boost. This also results in physical conditioning and lessens cardiac work for a given amount of exercise. They also recommend anticoagulants, but as mentioned earlier, no randomized studies have been done to test their efficacy. Many patients will improve with this therapy and may not need surgery.

What patients with unstable angina are at high risk of infarction and/or death? In the studies quoted previously, patients most likely to infarct are those with the onset of angina decubitus, with continuing rest pain after two days of hospitalization, or with persistent ST abnormalities on electrocardiogram. These patients may do better with coronary bypass surgery than with medical therapy alone. Bertolasi et al.[11] have recently reported initial results in a randomized study of surgery and medical therapy in patients with recurrent rest pain and also in patients with pro-

(Continued on page 436)

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
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Washington, D.C. 20005



gressive angina. In the former group, mortality in the surgically treated patients was 8.5 per cent after one year; in the medically treated patients it was 35 per cent. Dr. Gazes has reported similar findings in a nonrandomized group. The numbers are small and details of important risk factors such as cardiomegaly, hypertension and previous infarction are not available.

Other reports of surgical treatment of unstable angina lists a surgical mortality of 0-22 per cent with a perioperative infarction rate of 9-15 per cent.[1, 2, 12] These rates are not really different from the natural history of new onset angina or progressive angina. Surgical mortality can be improved dramatically if surgery can be delayed until the patient is stabilized.[12] In all studies in which medical and surgical patients are compared, many more patients having surgery are pain free and have improved tolerance when tested. Thus, if vigorous medical therapy does not relieve pain then surgery is indicated.

In summary, many patients with unstable angina will do well with good medical therapy. Those with recurrent rest angina or disabling pain in spite of medical therapy should probably have coronary angiography and, if suitable candidates, consideration for coronary bypass surgery. In these patients, pain can be relieved by surgery and mortality may be improved. More long term, randomized studies are needed to confirm the latter impression and determine the role of surgery in other syndromes of unstable angina. Bypass surgery should be thought of as palliative. Vigorous treatment of all risk factors such as hypertension, lipid abnormalities, etc., must be continued postoperatively, hopefully retarding the progression of the atherosclerotic process. ■

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Synopsis of MAG Suit Against Medicaid

J. WINSTON HUFF *and* ROBERT W. PATRICK, *Atlanta**

THE FULL TEXT of the MAG suit attacking the Georgia Department of Human Resources' Medicaid policies is reproduced following this article. The purpose of this article is to give you a brief summary of this suit which was filed on October 9, 1975 in the United States District Court for the Northern District of Georgia.

The plaintiffs in this suit are The Medical Association of Georgia on behalf of its members; J. W. Chambers, M.D., of La Grange, Georgia; C. E. Bohler, M.D., of Brooklet, Georgia; and two Medicaid-eligible patients who are residents of Georgia. The defendants are F. David Mathews, as Secretary of the Department of Health, Education and Welfare; Governor George Busbee; T. M. Parham, as Commissioner of the Department of Human Resources; and Sam T. Thurmond, as Director of the Medicaid Program. As will be seen, the burden of the lawsuit is that the State Medicaid policies adversely affect not only Georgia's physicians, but patients as well.

The complaint alleges that Title XIX of the Social Security Act (Medicaid) requires that the State adopt a "State Plan" complying with the Federal Law in order for the State to qualify for Medicaid matching funds. It is alleged that the State of Georgia has adopted a plan which has been approved by the Secretary of Health, Education and Welfare. The defendants, Department of Human Resources, and Messrs. Parham and Thurmond are said to have promulgated a Manual of policies and procedures for physicians' services and a Provider Agreement. It is charged that the Provider Agreement requires all physicians participating in the Medicaid program to conduct themselves according to the Manual and prohibits participation in the Medicaid program by physicians who do not sign the Provider Agreement.

Effects on Patient and Physician

The complaint then deals with the effect of the Manual and Agreement on both patients and physicians. It is pointed out that the Medicaid Act and the Regulations assure that a Medicaid-eligible patient has the right to obtain treatment from any person licensed and qualified to perform the services and that the patient has the right to select a provider of his own choosing. It is also stated that the Manual requires a physician to administer the least expensive treatment in all cases where there is more than one available method of treatment of probable equal results, whether or not the least expensive treatment is, in the physician's judgment, the best treatment. Therefore, the suit concludes that this policy interferes with the patient's free choice, interferes with the relationship between the physician and his patient, and interferes with the physician's constitutional right to practice medicine according to his best judgment. This policy also affects the patient's constitutional right to be treated according to the best judgment of his physician. It is charged that the Manual and the Provider Agreement have the effect of lowering the stan-

* Prepared at the request of The Medical Association of Georgia. Mr. Huff and Mr. Patrick are partners in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

dard of medical care afforded Medicaid patients. Also it is stated that these policies encourage the establishment of dual standards of care by dictating the mode of treatment which conflicts with the patient's right to access to quality care under the Act and also violates his rights under the Equal Protection clause of the Fourteenth Amendment to the United States Constitution.

The suit alleges that the Act and the Regulations require that a State Plan be designed so as to encourage the participation of a wide range of physicians, to the end that Medicaid recipients will receive the same extent and quality of care as is available to the general public. It is complained that the Manual and the Provider Agreement have the effect of discouraging physicians from participating in the Program and thus are in violation of this policy.

Rights Violated

The lawsuit shows that the physician-members of MAG and the two named plaintiff-physicians treat Medicaid patients, and that in the course of their practice they must determine the kind and extent of treatment which is required for a patient. These decisions are made on the basis of their best professional judgment under the circumstances. It is stated that the provisions of the Manual and the Agreement interfere with the free exercise of the professional judgment and therefore violate both the Medicaid law and the physicians' constitutional rights. The complaint also points out that the Provider Agreement will permit the State to reduce physicians' fees and also to terminate the Agreement with no obligation to pay for services already rendered. This is attacked as being violative of the Social Security Act and of the physicians' constitutional rights.

The suit charges that the process of adoption of the Manual and the Provider Agreement by DHR did not comply with the Georgia Administrative Procedure Act and that the plaintiffs were not afforded a reasonable opportunity to be heard. Also, it is alleged that the adoption of the Manual and the Provider Agreement represents a change in the existing State Plan which is required to be approved by the Secretary of HEW. It is stated that if in fact HEW has approved this change, then the defendant Mathews, Secretary of HEW, in so approving the Plan has deprived the plaintiffs of their lawful rights.

The complaint asks the Court to declare that the Manual and the Provider Agreement violate the Social Security Act, the Regulations, and the rights of the plaintiffs secured by the United States Constitution. The Court is asked to enjoin the defendants from requiring physicians to practice medicine according to the terms of the Manual and from requiring physicians to sign the Provider Agreement in order to participate in the Medicaid program. ■

(Ed. note: MAG's application for a preliminary injunction has been referred to a three-judge court. At this writing the date of the hearing has not been set.)

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA, ATLANTA DIVISION

Medical Association of Georgia, on behalf of its members; J. W. Chambers, M.D.; C. E. Bohler, M.D.; Helen Linebarker; and Carston S. Irwin,

Plaintiffs

vs.

F. David Mathews, in his capacity as Secretary of Health, Education and Welfare; George Busbee, individually and in his capacity as Governor of the State of Georgia; T. M. Parham, individually and in his capacity as Commissioner of the Department of Human Resources of the State of Georgia; Sam T. Thurmond, individually and in his capacity as Director of the Medicaid Program for the State of Georgia,

Defendants.

1.

This action arises under the Social Security laws of the United States, Title XIX Social Security Act, 42 U.S.C.A. §1396, et seq., and under 28 U.S.C. §1331 conferring jurisdiction upon the District Courts of the United States, where, as here, the matter in controversy exceeds the sum of $10,000, exclusive of interest and costs, and arises under the laws of the United States and the Constitution of the United States. This action also arises under 42 U.S.C.A. §1983 and 28 U.S.C. §1343(3) and (4) for the resolution of the substantial Constitutional questions herein presented and the redress of the deprivation of rights and privileges secured to the plaintiffs under the First, Ninth and Fourteenth Amendments to the Constitution of the United States.

2.

The plaintiff, Medical Association of Georgia, hereinafter the Association, is an incorporated association, the membership of which consists of approximately 4300 physicians who practice their profession and reside in Georgia. Many of the plaintiff's members regularly treat and furnish medical services to eligible recipients of benefits under the Medical Assistance Program for the State of Georgia. The plaintiffs, J. W. Chambers, M.D. and C. E. Bohler, M.D., are members of the Association, are citizens of the United States and residents of Georgia. They are licensed as physicians in the State of Georgia and practice medicine in Georgia. They regularly treat and furnish medical services to eligible recipients of benefits under the Medical Assistance Program for the State of Georgia and to other patients who are not covered by this program. In the course of their practice, they must frequently determine the particular type and extent of medical treatment for a patient that is required. They make these medical treatment decisions on the basis of their best professonal judgment concerning the particular circumstances of an individual patient's condition and medical history. However, the unlawful provisions of the Manual and Provider Agreement, hereinafter identified, promulgated by the defendants Parham and Thurmond have unduly interfered with the exercise of these plaintiffs' best professional judgment by injecting considerations of whether particular medical treatments will be compensated under the State Medicaid Plan, as a factor in the medical treatment process. The plaintiffs have already suffered great pecuniary loss under these unlawful provisions, through the administering of medical services which have gone uncompensated. If future such violations of the plaintiffs' rights under federal law and the Constitution of the United States are not enjoined, the plaintiffs will each be damaged in excess of $10,000.00.

3.

The plaintiffs, Helen Linebarker and Carston S. Irwin, are citizens of the United States and residents of Georgia. They are entitled to receive and have received benefits under the Medical Assistance Program for the State of Georgia and regularly receive medical care and services thereunder. They desire to receive medical treatment in accordance with the best medical judgment of their attending physician and are entitled by law to receive such treatment. The unlawful provisions of the Manual and Provider Agreement promulgated by the defendants Parham and Thurmond will result in denial of certain medical treatments of the plaintiffs that would otherwise have been provided in accordance with the best professional judgment of their personal physicians. If further violations of the plaintiffs' rights under federal statutes and the Constitution of the United States are not enjoined, the plaintiffs will each be damaged in excess of $10,000.00 through deprivation of their right to medical treatment in accordance with the best professional judgment of their attending physician.

4.

The defendants are F. David Mathews, in his capacity as Secretary of the United States Department of Health, Education and Welfare; George Busbee, individually and in his capacity as Governor of the State of Georgia; T. M. Parham, individually and in his capacity as Commissioner of the Department of Human Resources for the State of Georgia; Sam T. Thurmond, individually and in his capacity as Director of the Medicaid Program for the State of Georgia.

5.

Title XIX of the Social Security Act, 42 U.S.C.A. §§1396 and 1396a, et seq., requires that in order for a state to qualify for medical assistance funds to be furnished by the United States and to be used by the state to provide for a program of medical care and services to eligible recipients as described in the plan and in Title XIX of the Social Security Act, 42 U.S.C.A. §§1396 and 1396a, et seq., the state must submit for approval to the Secretary of the United States Department of Health, Education and Welfare, a state plan which must meet certain minimum criteria more specifically set forth in 42 U.S.C.A. §1396a.

6.

Prior to the acts complained of herein, the Department of Human Resources for the State of Georgia sub-

mitted and had approved by the Secretary of the United States Department of Health, Education and Welfare, a state plan. This plan shall hereinafter be referred to as Medicaid.

7.

On or about May 21, 1975, the defendants, Parham and Thurmond, together with the Department of Human Resources for the State of Georgia, acting under color of state law, promulgated a manual of Policies and Procedures for Physician Services (hereinafter the Manual), which specified the procedures for care and treatment of patients by physicians and other providers who furnish medical services to eligible recipients under the State Medical Assistance Program (Medicaid).

8.

In addition, the defendants, Parham and Thurmond, together with the Department of Human Resources for the State of Georgia, acting under color of state law, promulgated a Provider Agreement. The Provider Agreement requires that physicians and providers of medical services who sign this Agreement agree to conduct themselves, with respect to Medicaid recipients whom they service, according to the Policies and Procedures set forth in the Manual. These defendants have insisted that all physicians and providers who wish to participate in the Medical Assistance Program for the State of Georgia must sign this Agreement.

9.

In adopting the Policies and Procedures set forth in the Manual, referred to in Paragraph 7, and the Provider Agreement which providers of medical services under the Medicaid Program are required to sign, referred to in Paragraph 8, the defendants Parham and Thurmond did not comply with the Georgia Administrative Procedure Act, Ga. Code Ann. §3A-101, et seq. These defendants did not give the proper notice required by this Act to the plaintiffs of the intended adoption by the Department of Human Resources of said rules, and failed to provide an opportunity for the plaintiffs as interested persons to present their views thereon, as required by the Georgia Administrative Procedure Act. Furthermore, said rules and regulations were promulgated in an arbitrary and capricious manner without clear legislative authority by the State Assembly or Congress.

10.

These defendants' failure to comply with the Georgia Administrative Procedure Act renders the aforementioned policies and procedures set forth in the Manual and Provider Agreement void. These defendants' enforcement of such provisions constitute an attempt to deprive the plaintiffs of due process of law as guaranteed by the Fourteenth Amendment to the United States Constitution.

11.

The Manual represented a substantial change in the existing state plan approved by the Secretary of Health, Education and Welfare. The Manual which revised the state plan was not submitted by the defendants Parham and Thurmond for approval by the Secretary of Health, Education and Welfare in accordance with the requirements of Title XIX of the Social Security Act and the regulations thereunder. This revised state plan further failed to meet the minimum criteria for state plans set forth in Title XIX of the Social Security Act and the regulations thereunder. This action violated the plaintiffs' rights under Federal Statutes as secured by Article VI and the Fourteenth Amendment to the United States Constitution.

12.

If the United States Department of Health, Education and Welfare has approved or acquiesced in the provisions in the Provider Agreement and the Manual adopted by the Department of Human Resources of the State of Georgia, then this action was in violation of the provisions of the Social Security Act, as alleged herein. The defendant Mathews, in his capacity as Secretary of the United States Department of Health, Education and Welfare, has thus denied the plaintiffs their constitutional rights to due process of law, as secured by the Fifth Amendment to the Constitution of the United States. The defendant has further interfered with other Constitutional rights of the plaintiffs secured by the First, Fifth and Ninth Amendments to the Constitution hereinafter identified.

13.

As a condition to participation in the State Medicaid Program, the defendants Parham and Thurmond have required physicians and other providers of medical services to enter into a Provider Agreement with the State Medicaid Program whereby they agree to provide medical services to Medicaid recipients according to the policies and procedures set forth in the Manual, whether or not these policies and procedures correspond with the treating physician's best medical judgment.

14.

Title XIX of the Social Security Act and the regulations issued thereunder guarantee that a person eligible for benefits under a state plan is to be provided with such medical services that will assure the recipient of a quality of care consistent with that available to a person not receiving Medicaid benefits.

15.

Title XIX of the Social Security Act and the regulations issued thereunder guarantee that any individual eligible for Medicaid benefits can obtain medical treatment from any person qualified to perform the service or services required, who undertakes to provide him such services. The Social Security Act guarantees Medicaid recipients the right to choose a provider of medical services for them under the Medicaid Program.

16.

A provider of medical services is required according to the terms of the Manual, to administer the least expensive treatment to Medicaid benefit recipients in all cases where there is more than one available method of treatment and each such method produces essential-

ly the same medical results, whether or not the least expensive treatment is the best treatment according to the best medical judgment of the treating physician.

17.

By requiring the physician members of the plaintiff Association to administer the least expensive method of treatment and to consider the expense of a method of treatment prior to administering to a Medicaid benefit recipient, the Manual and the Provider Agreement directly interfere with the relationship between the doctor and patient in that they interfere with the physician's constitutional right to practice medicine according to his best judgment and the patient's constitutional right to be treated according to the best judgment of the physician of his or her choice, secured to the plaintiffs by the First, Fifth, Ninth, and Fourteenth Amendments to the Constitution of the United States. The Manual and the Provider Agreement have the effect of lowering the standard of medical care and service specified by Title XIX of the Social Security Act and the regulations issued thereunder.

18.

By requiring the physician members of the plaintiff Association to administer the least expensive method of treatment and to consider the expense of a method of treatment prior to administering to a Medicaid benefit recipient, the Manual and the Provider Agreement encourage the establishment of dual standards of care by dictating the mode of treatment; this is a deprivation of a Medicaid benefit recipient's access to quality medical care guaranteed by Title XIX of the Social Security Act, and the regulations issued thereunder. The Manual and Provider Agreement thereby violate the plaintiff Medicaid benefit recipient's constitutional rights to equal protection of the laws under the Fourteenth Amendment to the Constitution of the United States.

19.

The terms of Title XIX of the Social Security Act and the regulations issued thereunder, require that a state Medicaid plan must be designed so as to encourage the participation of a sufficient number of physicians in the plan so that eligible recipients can receive the medical care and services included in the plan, at least to the extent such services are available to the general public.

20.

The Manual and the Provider Agreement which require that physicians sign a contract with the State of Georgia to provide medical services at the direction of the State restrict Medicaid benefit recipients' access to medical care by discouraging physicians from participating in the program. This violates these plaintiffs' rights under federal statutory law as secured by Article VI and the Fourteenth Amendment to the United States Constitution.

21.

Title XIX of the Social Security Act and the regulations issued thereunder, require that a state plan must provide a specific manner of compensating the providers of medical services to Medicaid recipients for all reasonable charges.

22.

The Manual requires providers of medical services to sign the Provider Agreement which specifies that, in the event that the State of Georgia fails to appropriate sufficient funds to fully compensate all the providers enrolled in the state plan, the provider will agree to accept, as full compensation for the medical services rendered, a pro rata share of the amount of funds available or, in the event no funds are available, to waive any right, claim or action which they may have to claims for medical services rendered which are not paid.

23.

The Manual and the Provider Agreement deprive the plaintiff physicians of equal protection of the law and further deprive them of property without due process of law, because they purport to authorize the State of Georgia to compensate physicians in an amount which is lower than that contemplated by Title XIX of the Social Security Act and the regulations issued thereunder, and to refuse to compensate them at all.

24.

The Manual and the Provider Agreement, by purporting to authorize an allocation of funds which is less than the allocation of funds required by the Social Security Act and the regulations issued thereunder, violates the federal rights of the plaintiff Medicaid recipients secured by Article VI and the Fourteenth Amendment to the United States Constitution.

WHEREFORE, the plaintiffs respectfully demand that the Court grant judgment as follows:

1. That this Court issue a declaratory judgment to the effect that the Manual and the Provider Agreement for the Medicaid Program for the State of Georgia are in violation of Title XIX of the Social Security Act, and the regulations issued thereunder, and thereby violate the plaintiffs' rights under federal statutes, secured by Article VI and the Fourteenth Amendment of the United States Constitution; and furthermore are in violation of their constitutional rights under the First, Fifth, Ninth and Fourteenth Amendments to the United States Constitution.

2. That this Court temporarily and permanently enjoin the defendants from requiring the plaintiff physicians and other physicians in Georgia to practice medicine according to the terms of the Manual.

3. That this Court temporarily and permanently enjoin the defendants from requiring that the plaintiff physicians and other physicians in Georgia sign and be bound by the Provider Agreement in order to participate in the Medicaid Program.

4. That this Court award plaintiffs reasonable attorney's fees together with the cost of these proceedings and such other and further relief as this Court deems just and proper.

Robert W. Patrick
J. Winston Huff
Jerry B. Blackstock
Attorneys for the Plaintiffs

One Physician's Thoughts on the Medicaid Situation

The letter below was sent by Atlanta orthopedic surgeon John W. Gamwell to Sam Thurmond, Director of the Georgia Medicaid Program, and expresses well his reaction to the Medicaid Manual and Provider Agreement.

September 26, 1975

Mr. Sam Thurmond, Director
Medicaid Program
Georgia Department of Human Resources
47 Trinity Avenue, S.W.
Atlanta, Georgia 30334

Dear Mr. Thurmond,

There is a document which starts, "When in the course of human events," that goes on to list certain abuses and grievances which the authors believed were current and important enough to set down in writing for all to see. This list of grievances explained what was deemed to be external threat to the well-being and safety and happiness of the people of a young country. Within recent decades there have arisen many *internal* threats to the safety of this same country, which have had the effects of lessening individual liberties and of strengthening the hand of government. I refer to the growing power and authority of our federal government in Washington, at the expense of the rights of the states and their citizens. This process also has reached the point where the states, or at least some of them, are trying to increase their authority at the expense of the liberties as well as the responsibilities of the people. The most recent effort along these lines is the Medicaid Provider Agreement and Manual.

As Dr. Earnest C. Atkins pointed out recently in an article in the August 1975 issue of the *Journal of the Medical Association of Georgia,* by signing the provider agreement the physician confirmed that he became an agent of the State. I assume that in your position, you elected to become such an agent. Most physicians and most citizens have not, and indeed have resisted such a trend. I also would point out that this concept is just the opposite of one of the primary principles of the founding of this country. The state is supposed to be the agent of the people, and not vice versa.

Medicaid Problems

Following are some of the problems with Medicaid.

With respect to the Provider Agreement, the fact that you require a physician to sign such a lengthy document is, first of all, more bad than good, and I think those physicians who elect to sign it will find it to their detriment before too long, and I also suspect that patients unwittingly will too. Paragraph four says that the physician must be ready to furnish the state agency with information that will fully disclose the extent of the services provided to Medicaid patient, as the state agency may from time to time request. How much information do you need, beyond what has been supplied on the individual claim forms that have been used in the past, and why would disclosure of such information not violate the confidentiality of the doctor-patient relationship? This information apparently is to be supplied at the physician's time and expense, despite the threat that the physician's charge may be reduced or entirely eliminated. Paragraph five states that if federal matching funds are not available to the state agency for Medicaid, then no claim for reimbursement shall be paid by the state. You imply that physicians should make their services available with no certainty whatsoever that they will be reimbursed for these services. Paragraph six says a similar thing, in that you may reduce the amount of reimbursement by a so-called factoring method or technique, "as often as it deems advisable during the term of this provider agreement." These decisions are to be made by resolutions adopted by the Board of Human Resources, apparently without any kind of recourse or due process on the part of physicians. There is nothing in the founding documents of the countries of western civilization, in religious teachings, or in human codes of ethics which says that physicians, or any other group, should make their services available under such stipulated restrictions. Paragraph eight gives you the authority, or seems to, to terminate the provider agreement any time you no longer desire to authorize reimbursement for the medical care or services. Paragraph nine states that reimbursement will no longer be available any time the General Assembly of the State of Georgia or the Congress of the United States of America, or a combination of the two, stops providing sufficient funds, and that the provider agreement shall immediately terminate without further obligation of the state agency "as of that moment."

This list of stipulations is all completely one-sided in your favor, and leaves the signee truly an agent of the State. Personally I do not think a private physician's income or livelihood should be so readily at your disposal.

Responding to Manual

With respect to the Manual, including the revisions and modifications that have been made, to expect the Medical Association or profession to respond to your original Manual within four days borders on the ludicrous. What state or government agency has ever undertaken such a task and completed it within four days? You will note that it was a private organization which was able to respond so quickly. The fact that private organizations are able to accomplish things more readily and more efficiently and less expensively than public ones, is a fact of human culture that Medicaid and no other public program can change. Notice that North Carolina has recently turned over the administration of its Medicaid program to a private agency.

You leave it to the physician to check an individual's Medicaid card, to see if it is current, and also to record several items on the card. Again you require time and effort on the part of the physician above what he has previously had to do, and at his own expense. You leave it to the physician to determine if the patient has other health insurance but you do not allow the physician to collect from this insurance beyond what Medicaid will pay. Indeed we are supposed to go to this extra time and effort, but if it proves rewarding, we are supposed to turn the extra money back over to you. What do you intend to do with this money? And why should you have the prerogative to unilaterally cut back on payments, and in the same agreement say that physicians may not bill for their usual and customary amount?

With respect to the prudent buyer concept, the idea of utilizing the less expensive treatment will mean a lesser quality of care, and this stipulation runs counter to the physician's charge of providing the highest quality medical care possible.

With respect to the section on prior approvals, the stipulation is that the physician may request prior approval for a treatment plan, or an extra hospital visit, or an extra office visit, etcetera, as he thinks may be indicated. As I read the Manual, there is no certainty that these requests will be approved. Again there is the implication that the physician may not be reimbursed for doing what he considers necessary to provide quality or even adequate medical care. The stipulations that the physician may be reimbursed for seeing a patient only once a month in the office or once a day in the hospital completely ignores what is necessary to treat many kinds of patients with many kinds of problems.

In my particular field, intraarticular aspirations and injections are a fairly frequently utilized mode of treatment. I think for you to require written medical justification, whether in advance or otherwise, may be a bit beyond reason.

There are other objectional elements to the Manual, in the sense that they are an extra burden on the physician's time and effort and expense, and do not contribute anything to quality medical care. Indeed their effect is the opposite.

Cost Control?

I gather that the main thrust of this latest Provider Agreement as well as the Manual is cost control. I am not at all certain that this will be the effect. It *might* initially decrease the cost to the State, but it will increase the cost to the physician of seeing these patients, while at the same time leaving you reasons not to reimburse the physicians. The concept of making available so-called free medical care, or at least medical care at a greatly reduced expense to the patient, will encourage increased and probably over utilization by patients. This result will *increase* the cost of Medicaid to the State. The concept of "free care" has some inconsistencies with motivation to get well or regain good health. I also think that the concept of Medicaid is basically inconsistent with the concept of high quality medical care, and is becoming more and more so.

Certainly the efforts of Governor Busbee and others do not go unrecognized by physicians. The federal stipulations are as bad as some of the State ones. The requirement that has prohibited families and patients from helping to pay the cost of intermediate nursing home care is absurd, and should be changed for all the states.

There is nothing more basic than living within one's means, and there are better ways to control the cost of the state Medicaid program, other than the stipulations which you are placing on physicians. I think the best way is to change the criteria of eligibility to reduce the number of individuals eligible to a level which you can provide for financially. Trying to do more is to the disadvantage and detriment of everyone involved. Such a change, I understand, would require revisions in federal regulations and perhaps in federal legislation. If that be the case, then the states should all lobby for the needed revisions.

There is nothing inherently "equal" about someone's being on welfare and needing to have their health services all paid for, and many receiving welfare money are able to contribute toward the cost of their health care.

A program which was ostensibly intended to be temporary and helpful is becoming abused and abusive, too costly, uncontrollable, and counter productive of provider ability and willingness to provide services.

This latest effort of yours, or at least what you represent, needs to be improved upon in order not to be a major contributing factor to the on-going decline and fall of the United States.

Sincerely yours,
John W. Gamwell, M.D.

25 Prescott Street, N.E.
Atlanta, Georgia 30308

I've told this before . . . .

(Ed. note: Others wishing to contribute stories to this feature page should send them to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

A Fish Tale

BACK IN THE LATE '40s, one of my uncles, Charlie Cowan, asked some of his nieces and nephews to come down to his summer place at Steinhatchee, Florida and fish. All reports were that the "reds" were in the river. It was in the spring and the weather had been cool.

We arrived late in the afternoon, went down to the cleaning table and found scales of "reds" that they had caught the day before—some as big as a thumbnail. In the ice box they had left us one trout and one red. We were so enthusiastic that we immediately went down and got some shrimp and fished off the dock until black dark . . . no luck!

Just at dawn, my brother-in-law by the name of Joe Burkett and I shoved off, full of enthusiasm and vinegar. We were amazed at how many people were in boats on the Steinhatchee River. The word had evidently spread that the fish were biting. Boats were everywhere.

We found a cove and fished and fished . . . no luck . . . and no one else was catching any. We changed places and changed places, used shrimp, then artifical lures of all kinds. We did not get a bite, nor did we see anyone else get one.

Finally I said to Joe, "Let's go down and get some mullet." I had heard that occasionally red fish or trout would bite cut mullet when they would not bite anything else. Away we went about two miles down the river and bought several three to four pound mullet. We cut slivers off one of them and fished on the way back up the river.

We came to a beautiful bend in the river. It must have been a quarter mile wide at this point, and there were at least 40 boats fishing in this great bend, all anchored. We decided that this must be a good place to fish because of the number of fishermen and fisherwomen so enthusiastically casting their bait into the beautiful clear water. Despite the fact that we saw no fish being caught, we decided to try it here. The only vacant spot was on the inside bend, where the current was fairly swift and you could look down and see the bottom, which was covered with big rocks. We anchored and I told Joe after I had perused the bottom carefully, that I could not see any fish, and that if there were no fish there, how were you going to catch one. Joe, however, was an optimistic soul, and he said that they might be hiding in the crevices of the rocks.

And so we fished. By this time it was close to noon. I was a little tired, hungry and had developed quite a thirst. I reeled in to check my bait, which was in just the same condition as it was when I put it out. I noticed that Joe was changing hooks or something and not looking my way. So I hooked the biggest mullet we had through the lip and gently put him over the side letting him drift with the current. After he had drifted some 50 feet, I jerked my rod and shouted, "Joe, I got one, get the net." I made all sorts of "do-dads" with my rod pulling his dead mullet against the current. Joe turned over his tackle box getting the net. When he netted him, I cannot print exactly what he said, especially as he eyed his tackle scattered in the bottom of the boat.

But he forgave me when we looked out over this vast expanse of water and saw everybody anxiously reeling in and checking his bait, and hear one calling to another that that man in the brown shirt near the bank had just caught a big one.

Then Joe put on a mullet, let him drift down and hollered "get the net." The boat had an inch or two of water in the back end and we sloshed these mullet around in it as though they were alive and kicking. One time Joe cussed me out because I theoretically missed one with the net and let him get away.

We must have caught those big mullet 10 or 15 times. We were hungry and in need of a libation and feared that some smart fisherman might get on to us. So I said in a loud voice, "Joe, we got all we can eat, let's go home." He said "okay" and as we upped anchor we heard 10 or 15 motors "crank up." As we rounded the bend and looked back, there was a race for our spot.

We ate those mullet for lunch and they were good.

The next morning we went down to the fish market to get some fish and shrimp to take home with us. My sister Azilee asked Mr. Pluckett if anybody had caught any fish and he said no . . . no . . . nooooo . . . nobody in the river or in the flats. But after a minute or two he said, "Now I'll take that back . . . several people said that two men from the Cowan cottage had caught eight to 10 reds on the inner bend of the river, up here about a mile or two." Now he went on to say, "I believe it and I don't believe it."

He weighed out the fish and the shrimp, then resumed his conversation. "I've been here for, let me see now—26 years, come October 15th, and I ain't never knowed nobody to ketch any fish where they was a fishing. The water ain't 10 foot deep and the current is swift and theys' big rocks all over the bottom . . . but Ezra Brooks come in here last night and he's a hard shell Baptist preacher. Now Ezra ain't much of a preacher, but they ain't nobody, including me, that ever knowed of Ezra telling a lie, and he said that he was a setting in his boat about as far as . . . let's see . . . about twice as far as here across the road . . . and Ezra said that he seen 'em ketch about 10 nice sized reds."

"And so in answer to your question, Miss . . . I would say nobody much has caught any fish . . . and by the way . . . ain't y'all a staying at the Cowan cottage?"

J. G. McDaniel, M.D.
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Atlanta, Georgia 30327

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SOCIETIES

The **Cobb County Medical Society** held a joint meeting with the Cobb Judicial Circuit Bar Association in September, with Cotton Fitzsimmons, coach of the Atlanta Hawks as guest speaker.

The October meeting of the **DeKalb County Medical Society** was a discussion of "Alcoholism: Diagnosis and Treatment" by G. Douglas Talbott, M.D., director of the DeKalb County Alcohol and Drug Abuse Program and Kenneth Shoemaker, M.D., medical director of the DeKalb County Mental Health Services. Bo Callaway, Secretary of the Army and campaign manager for President Ford, will be the featured speaker at the November 15 joint meeting of the DeKalb County Medical Society and the DeKalb County Bar Association, held at the Atlanta Athletic Club.

PERSONALS

First District

Leon Curry, Metter, was the guest speaker on renal dialysis for a recent meeting of the First District, Georgia Nurses' Association at Chandler County Hospital.

Stephen R. White and **Paul A. Whitlock, Jr.,** have opened a surgical clinic in Statesboro. Dr. Whitlock is a Carrollton native who earned his M.D. degree from Emory University. Dr. White was born in California, and also is an Emory alumni.

Second District

W. O. Holloway, Tifton, has been re-appointed to a second term as chief of staff at Tift General Hospital.

Frank Bowyer will serve as vice-chief and **Tom L. Edmondson** is secretary-treasurer.

Fourth District

Decatur physician **Ron F. Shotts** has opened an office on Old Salem Road in Conyers where he will see patients on Wednesday afternoons. He is an otolaryngologist who attended medical school at Ohio State University, and is board certified by the American Board of Otolaryngology.

L. C. Buchanan, Decatur, represented the Medical Association of Georgia in Washington in October, appearing before the House Ways and Means Subcommittee on Health. He spoke on the 19 amendments to PSRO as proposed by the AMA and MAG, and answered questions from the subcommittee members.

Benjamin B. Okel and Congressman Andrew Young debated the subject of national health insurance before an audience at North Decatur Presbyterian Church recently.

Fifth District

Bernard L. Hallman, professor of medicine at Emory has been appointed associate dean for continuing medical education. He has been in charge of educational television at the medical school for several years and will continue to operate the television broadcast and tape library.

East Point physician **James H. Larose** has contributed a chapter on "Radionuclide Therapy" to the recently published second edition of the *Textbook of Nuclear Medicine Technology*.

Three Georgia physicians surgeons presented a film, "Selective and Non-Selective Spleno-Naso-Renal Shunt" for the Clinical Congress of the American College of Surgeons in San Francisco, Calif. in mid-October. The physicians are **W. Dean Warren, Atef A. Salam** and Robert B. Smith, III, all associated with Emory University. Dr. Warren is professor and chairman of the Department of Surgery.

Sixth District

Longtime medical director at Clayton Mental Health Center, **Charles Hendry,** has resigned his position, but will continue as medical coordinator of partial hospitalization services.

Seventh District

William R. Thompson of Calhoun has been elected president of the Seventh District Medical Society, and will be aided by **Richard Gray** of Rome, vice president; **James J. Oosterhoudt** of Dalton, secretary-treasurer.

Eighth District

W. L. Pomeroy, Sr., now retired, who had practiced in Waycross for 47 years, was honored by the Ware County Medical Society in October. Dr. Pomeroy received his M.D. degree from Emory, and completed his internship and residency at Grady Memorial Hospital. He served the Ware County Medical Society as president at one time, and was a delegate to MAG on many occasions.

Tenth District

William E. Lotterhos, Augusta, has been named chairman of the Federal Drug Administration's Over-the-Counter Miscellaneous External Drug Evaluation Panel.

Carl Jelenko, III, has been awarded a grant from the National Institutes of General Medical Sciences for research in the subject, "Biochemical Effects of Burning of Skin."

Arthur Humphries heads the kidney transplant program at the Medical College of Georgia, which has been accepted for full membership in the 25-member Southeastern Organ Procurement Foundation.

DEATHS

G. W. Barker

St. Marys physician G. W. Barker, Jr. drowned September 24 in a tributary of the St. Marys River behind his home.

Dr. Barker was a native of Heard County, and had graduated from the Medical College of Georgia. He came to St. Marys to practice in 1949, was on the staff of Gilman Hospital and was an active member of the St. Marys United Methodist Church.

Survivors include his widow, Mrs. Dot Barker; daughter, Miss Diane Barker, both of St. Marys; three sons, G. W. Barker, Carrollton, Brad Barker and Robert Barker of St. Marys; three sisters; three brothers.

Benjamin Hartwell Boyd, Jr.

Retired Atlanta physician Benjamin Hartwell Boyd, Jr., died September 29 in St. Simons. Dr. Boyd had practiced in Atlanta 25 years after graduating from the University of Alabama and Emory University.

He was a founding Fellow of the American College of Obstetrics and Gynecology, Fellow of the American College of Surgeons, a director of the Blue Cross-Blue Shield and director of United Physicians Service. Dr. Boyd was a past president of the Georgia Association of Obstetrics and Gynecology, was on the staff of St. Joseph's Infirmary and Crawford W. Long Hospital and served on the faculty of Emory.

Survivors include his widow, Mrs. Margaret McCarty Boyd; daughters, Mrs. Sarah Boyd McCarter of Jacksonville, Fla.; and Mrs. Earl Barton, Jr. of Atlanta; step-mother and sisters.

James Augustus Redfearn

Former MAG president, James Augustus Redfearn, 93, died October 1 at his home in Albany. He was a Thomas County native who began his practice in Albany in 1911 after graduation from the University of Georgia in pharmacy and Emory University School of Medicine.

Dr. Redfearn served as president of MAG from 1942-1943, and was past president of the Second District and Dougherty County medical societies. He started several clinics in the Albany area, was a member of the Board of the YMCA and president of the Bank of Albany.

He is survived by his widow, Mrs. Elleighfare Muse Redfearn; two daughters, Mrs. Ernest Wetherbee, Jr.

and Mrs. Russell Kaliher of Albany; and a son, Dr. J. A. Redfearn, Jr. of Dalton.

William Grant Simons

William Grant Simmons, 64, of Sylvania, died October 7. He was active in his community as a former city alderman, member of the Rotary Club, and Shrine Club. He served his profession as past president of the Screven County Medical Society and First District Medical Society and member of the staffs of the Screven County Hospital and Jenkins County Hospital. He was selected Man-of-the-Year for Screven County in 1959-1960.

Dr. Simons was chairman of the Screven County Department of Public Health and served four and a half years as a flight surgeon for the U.S. Air Force Reserve, after 29 years of active service. He was a past chairman and founder of the Sylvania Recreation Department.

Surviving Dr. Simmons are his widow, Mrs. Mary Hudmon Simmons; two daughters, Mrs. Susan S. Ragains of Sylvania and Mrs. Charles T. Lester, Jr. of Atlanta.

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

Members of the House Ways and Means Committee's subcommittee on health have heard testimony from foreign physicians extremely critical of the federalized national health insurance (NHI) systems in their native lands and from seven U.S. physicians who urged lawmakers not to allow this country to stumble down the same path.

All witnesses were selected by subcommittee Republican minority members to counterpoise arguments made by liberal witnesses produced during the summer by Democrat colleagues.

The major theme of the American physicians was that Federal interference should be kept to a minimum. Five of the seven physicians suggested that some form of catastrophic insurance might be beneficial.

Clinton S. McGill, M.D., Portland, Ore., told the subcommittee that "freedom within the widest possible latitudes in the practice of medical care is an ingredient absolutely essential to the success of any NHI program."

John Hamilton, M.D., Rochester, N.Y., urged elimination of administrative red tape and proposed a catastrophic plan based on patients' ability to pay.

Marvin N. Lymberis, M.D., Charlotte, N.C., also spoke favorably of catastrophic coverage, warning that an omnibus bill might bankrupt the government and leave the present health system in a shambles.

John Burkhardt, M.D., Knoxville, Tenn., said NHI must be carefully planned, cannot be all encompassing, and must not interfere with the doctor-patient relationship.

David Masland, M.D., Carlisle, Pa., warned of a possible paper work explosion if NHI is enacted, urged use of private carriers rather than a Federal bureaucracy, and noted that social factors have the biggest impact on the health of the nation.

Brooker Masters, M.D., Freemond, Mich., said the nation does not have the resources at present for NHI. Rationing of services would be required, resulting in "medical care dictated by edicts in the Federal Registry" which would lead to "chaos."

Donald Quinlan, M.D., Northfield, Ill., read a strongly-worded statement opposing any new Federal programs as "compulsory politicized medicine." He accused the Administration and Congress of the "great rip-off" of deficit financing.

The domestic panel was questioned by subcommittee chairman Dan Rostenkowski (D.—Ill.) and Reps. John Duncan (R.—Tenn.), James Martin (R.—N.C.), and Philip Crane (R.—Ill.). They praised the panel members for their testimony.

Asked by Rep. Charles Vanik (D.—Ohio) to give a show of hands on how many would support a catastrophic plan, six of the witnesses raised their hands, but none did when he asked for their sentiments on catastrophic health insurance operated by Social Security. Vanik contended that the public is pushing Congress on NHI, asserting that the lawmakers are not the innovators.

Foreign Physicians Testify

The foreign panel consisted of two British physicians, a British medical writer, a former Swedish physician, and a Canadian physician—Max Gammon, M.D., London; Reginald S. Murley, M.D., London; Anthony Lejeune, Middlesex, England, medical writer; Sigmund J. Lofstead, M.D., Chicago; and Bette Stephenson, M.D., Toronto.

As a group they urged Congress not to permit governmental control of medicine in this country.

The British witnesses painted a black picture of the situation in England. Dr. Murley said almost all physicians in England are totally opposed to the policies of the government and predicted a "massive confrontation" soon.

Dr. Lofstead, who had practiced in Sweden, said health care has become regimented and politicized in that country. Most people in the U.S. he said, have financial access to the best and most sophisticated health care in the world.

Dr. Stephenson was less critical of the Canadian program, but said any NHI program should involve as little distortion of the present U.S. system as possible. She said fee-for-service is the most efficient and fairest method of payment.

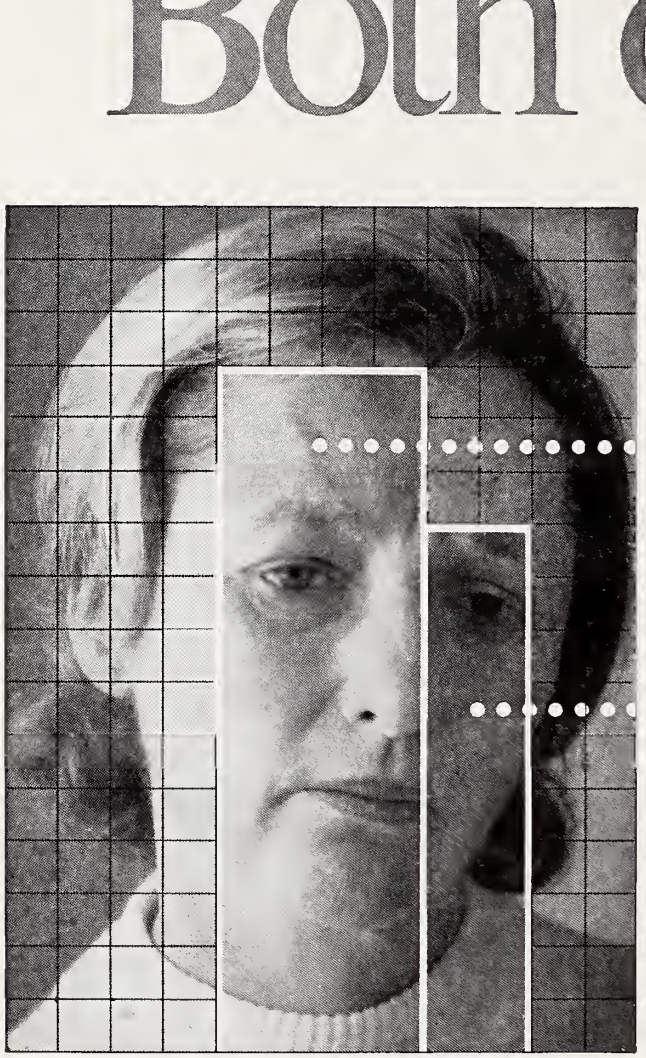
Dr. Gammon said it is imperative that the U.S. resist the socialization of medicine "for the good of the rest of the free world." He said that "if you believe that the state is better able to control the affairs of individuals then they are, then the prospects of freedom for the rest of the world are very dim." ■

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Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1975, Medical Association of Georgia.

Subscription rate: $7 per year in the United States, Canada and Mexico; $8 per year in foreign countries; $1 per single copy.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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Post-Mortem Removal of Donated Eyes for the Non-Ophthalmic Physician

JOHN C. HAGAN, III, M.D., *North Kansas City, Missouri**

THE CORNEA IS the clear, transparent tissue forming the anterior one-sixth of the eye. It provides the majority of the refracting power of the eye and by its transparency admits light to the interior of the eye initiating the complex process of perceiving formed visual images which we call Sight. The function of the cornea can be impaired by trauma and a variety of diseases, dystrophies and degenerations. In appropriately selected individuals corneal transplantation can lead to complete or partial restoration of sight. Transplantation of the cornea is the most frequently performed and successful human homograft. The success rate is steadily rising due to increasing knowledge of corneal physiology and immunology, better media for preserving the viability of the cornea when removed from the donor, and more sophisticated microsurgical instruments and techniques. There are an estimated 30,000 persons in the United States with blindness due to corneal disease who might benefit from a corneal transplant. Due to a chronic shortage of donor corneas only about 3,000 corneal transplants are performed in the United States each year.[1]

In an effort to increase the number of donor eyes the General Assembly of Georgia in 1972 approved an amendment to allow qualified morticians to remove eyes after death for donation to an eye bank. The licensed morticians are required to complete an approved course of instruction on how to perform the enucleation procedure. Since enactment of the amendment the Department of Ophthalmology of Emory University Medical School and the Lions Eye Bank, Atlanta have jointly conducted a semiannual course on the eye bank program and the procedure for removing donated eyes. This article describes the method of removing eyes post-mortem as taught in that course. It is intended as a guide should a physician be requested to remove eyes for donation to an eye bank in areas without an Ophthalmologist or qualified mortician.

Detailed description of the technique is outlined and discussed.

Instruments Required

A complete set of instruments and the required shipping containers have been distributed to all morticians after completing our course. The kit contains:

1 tissue forceps
1 eye lid speculum
1 Stevens scissors
1 enucleation scissors
4 sealed alcohol sponges
4 4 × 4 gauze squares
4 2 × 2 gauze squares
consent forms
2 identification tags
1 hemostat
1 eye muscle hook
1 pair sterile gloves
1 bottle Neosporin Ophthalmic solution
2 glass eye bottles with eye cages and screw tops
1 styrofoam shipping container sterile towels or eye drape

The Lions Eye Bank, Atlanta may be called 24 hours a day at (404) 377-2246 to obtain the location of the nearest mortician with this equipment. If the instruments are not available then much of the set can be assembled from Emergency Room or minor surgery stock. For the more specialized instruments certain substitutions may be made. A heavy curved Metzenbaum scissors can replace the

* Schertz-Allain-Hagan Ophthalmic Associates, 2700 Hospital Dr., North Kansas City, Missouri 64116. Formerly resident in ophthalmology at Emory University. Based on material presented in a course for morticians, sponsored by the Emory Department of Ophthalmology and the Lions Eye Bank, Atlanta.

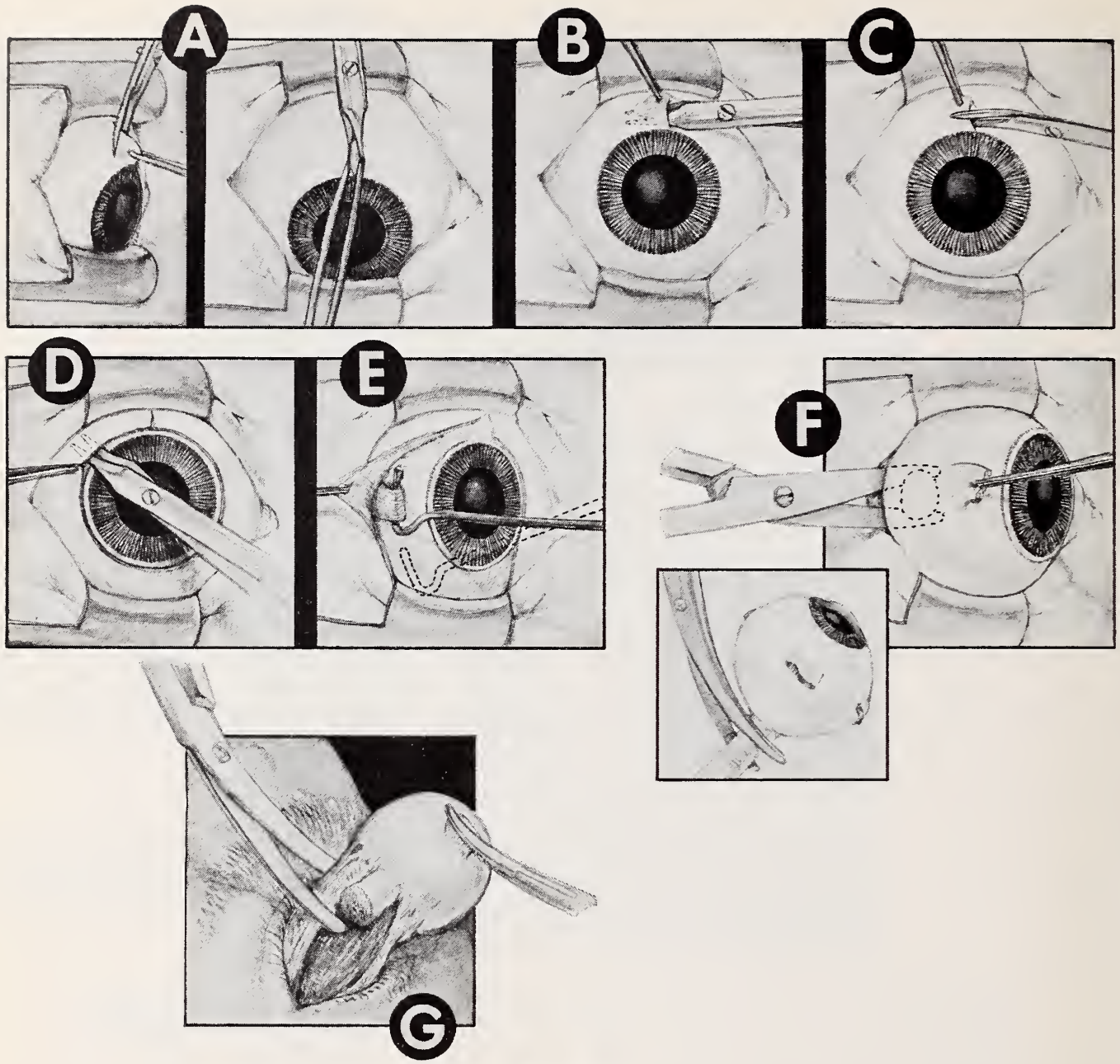


FIGURE 1

Diagram of the enucleation procedure used to remove eyes for donation to an eye bank. For description of above enucleation procedure see accompanying text.

enucleation scissors, a sharply angled hemostat will substitute for an eye muscle hook and an assistant may hold the lids apart instead of using an eyelid speculum. The eyes may be placed in small dry sterile glass jars as found in most hospital Pathology Departments. (These should not contain formalin, saline or any other preservative or fluid.)

The Enucleation Procedure

The ideal time for removal of the eyes is within two to four hours after death. If the eyes have been well covered by the lids and the body refrigerated then removal up to 10 hours after death is permissible. In general the sooner the eyes are removed the better. Age, cause of death, eye problems (cataract, etc.) do not preclude using eyes. If not suitable for transplantation, they are used for research or to teach ophthalmology residents ocular surgery.

The eyes should be removed only after proper written consent is obtained either from the next of kin or by means of a donation card signed before death by the donor. Proper identification of the body as that of the donor is essential. As with any operative procedure sterile technique is used. The procedure may be done by one person but an assistant will help greatly, especially to avoid breaking sterile technique.

Three structures must be cut to remove the eye: 1. the conjunctiva; 2. the six extraocular muscles; 3. the optic nerve.

1. Place a small table or Mayo stand near the head of the body and put an opened sterile towel on it.

The sterilized instruments, towels or eye drape, gauze squares and the two sterilized eye bottles and cages are placed on the towel.

2. Open an alcohol swab and use it to wipe the upper lid. A second swab is used for the lower lid. Wipe *towards* the eye being careful not to get alcohol on the eye.

3. Wash hands and don sterile gloves. Arrange the sterile towels to drape off the eye or arrange the circular hole of the eye drape over the eye.

4. Lift the upper lid slightly and slip one blade of the lid speculum beneath it, repeat for the lower lid.

5. Grasp the conjunctiva with the tissue forceps just above the superior cornea and cut it with the Stevens scissors (Figure 1A).

6. Insert the close scissors through the hole made in the conjunctiva and spread (Figure 1B).

7. Place one edge of the scissors below the conjunctiva and cut it (Figure 1C). Repeat steps 6 and 7 until the conjunctiva has been cut in a 360 degree fashion around the cornea. Be careful not to damage the cornea during the entire procedure.

8. Insert the closed scissors into the superior nasal quadrant and spread (Figure 1D). Repeat this procedure in the superior temporal, inferior nasal and inferior temporal quadrants. This maneuver separates tissue from the eyeball and makes removal easier. By going in the oblique quadrants traumatizing the recti muscles is prevented.

9. Slide the muscle hook back along the eye in the inferior oblique quadrant and swing towards the medial rectus muscle (Figure 1E). When the muscle is hooked pull it forward and clamp a hemostat on it near its insertion on the eyeball. Cut the muscle on the side of the hemostat *distal to the eye*. This leaves the hemostat attached to a stub of muscle inserted on the eye. This "handle" on the eyeball allows control and manipulation of the globe. The remaining three recti muscles should be similarly hooked with the muscle hook, pulled forward and cut without clamping with the hemostat. These muscles lie about 6-7 mm posterior to the cornea-scleral junction at the 12, 3 and 6 o'clock position. If the recti muscles cannot be located proceed to the next step and cut the remaining muscles while lifting the eye from the socket. The superior and inferior oblique muscles are located posteriorly on the eyeball and difficult to isolate. They are best cut when lifting the eye from the socket.

10. Use the hemostat attached to the muscle stub to lift the eye up and pull it temporally. Insert the enucleation scissors behind the eye and cut the optic nerve (Figure 1F).

11. Lift the eye out of the socket, cutting the remaining attached eye muscles and the attached fat and fascia (Figure 1G). Usually there is little or no bleeding in the orbit and it remains dry. If there is bleeding tamponade it with 2 × 2 gauze squares.

12. Place the eye on the sterile towel with the cornea up and rearrange the drapes over the other eye and repeat the procedure.

Preparing the Eye for Transportation

If an eye cage is available put the eye in it with the cornea up. The optic nerve goes through the hole in the bottom and a sterile pin or needle is stuck through it to prevent the eye from being dislodged (Figure 2). Put two sterile 2 × 2 gauze squares in the bottom of the eye jar and place the eye cage in the jar. Pour half the bottle of Neosporin

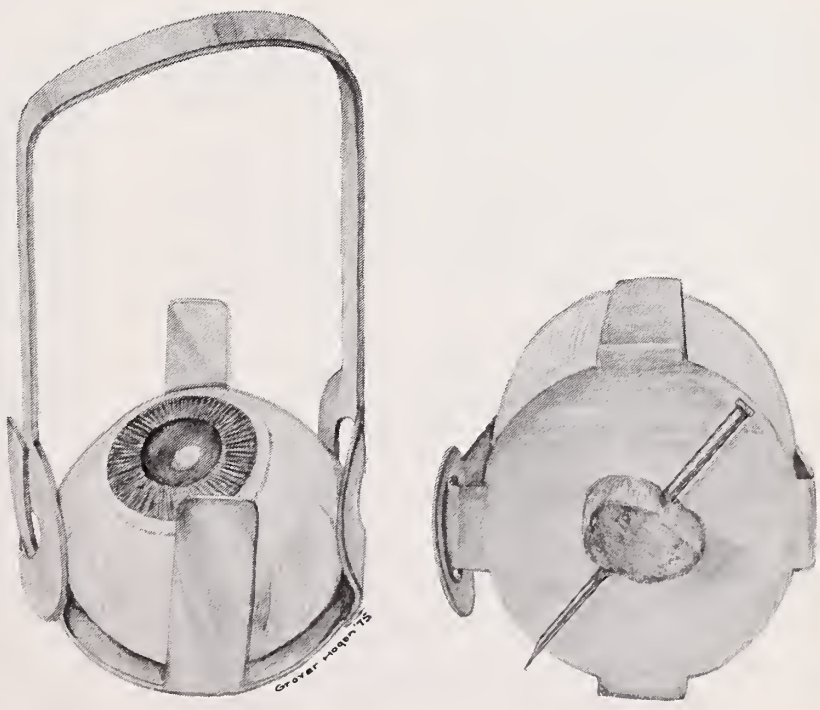


FIGURE 2

The enucleated eye is placed in an eye cage with the cornea up. (Left) The optic nerve is pushed through the hole in the bottom of the cage and a sterile straight pin stuck through it to prevent the eyeball from being dislodged. (Right)

over the cornea and apply the top. If no eye cage is available place several 2 × 2 gauze squares in the bottom of a sterile glass jar. Arrange them with a central depression, insert the eye with the cornea up in the central depression and pour half the bottle of Neosporin over the eye and apply the lid. Repeat for the other eye. Do not add any fixative or saline in jar! Don't place cotton or gauze directly on cornea.

Attach an identification card giving the patient's name, age, hospital number, date and hour of death, date and hour the eyes removed, the cause of death. Indicate whether the patient was on cytotoxic drugs or had a history of any known eye diseases. Attach also the written consent forms or donor card if available.

Place the eye jars with the attached ID cards in the styrofoam container and fill the container with ice cubes. Do *not* use dry ice. Tape the lid on. If the container is not available, then a wide mouth thermos jug filled with ice can be used. Do not put ice directly on eyes. The eye bank will return the thermos jug to the owner.

Call the nearest Eye Bank to alert them to expect the eyes. Arrange transportation to the eye bank, by calling the State Patrol or County Sheriff. Eyes sent to the Lions Eye Bank, Atlanta should be sent to Grady Memorial Hospital, 80 Butler St., S.E. and given by the law officer directly to the ophthalmology resident on call.

Summary

Corneal transplantation is a highly successful procedure and in certain corneal blind individuals can lead to complete or partial restoration of vision. In common with other organ transplantation procedures the number of possible recipients far exceeds the number of donors. Since 1972 morticians who complete a course on removal of eyes for donation purposes have been allowed to remove eyes postmortem. The method of enucleation used in that course has been presented for use by physicians who might be asked to remove eyes. In most areas eyes can be removed by ophthalmologists, ophthalmology residents or qualified morticians. It is also hoped that by awareness of the great need for donor eyes, the physician will inquire about donation of eyes at the time of death of one of his patients. All donated eyes can be used.

Information on details of removing eyes, the eye bank program, or names of nearby morticians who have completed our course are available 24 hours a day by calling (404) 377-2246.

This paper was supported in part by the Lions Eye Bank, Atlanta. I wish to thank Dr. L. A. Wilson for his assistance in preparing this paper. ■

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CHART REVIEW PROJECT TESTS INFECTION CONTROL MONITORING AT GRADY

Hospital-acquired infections are estimated to add some $1.5 billion to America's health care bill each year making it a major economic as well as public health issue.

Atlanta's U. S. Center for Disease Control, in a cooperative project with the Emory University School of Medicine and Grady Memorial Hospital, has initiated a test of retrospective chart review as a means of reliably monitoring hospital-acquired, or nosocomial, infection.

Directing the study are Dr. John E. McGowan, M.D., Grady epidemiologist and assistant professor of medicine at Emory, and Dr. Dennis A. Schaberg, M.D., medical epidemiologist for CDC's Bacterial Diseases Division.

According to Dr. McGowan, while infection control programs have been in operation at Grady and many other hospitals for several years, as yet no method has been devised to determine if the programs have in fact effectively reduced the risks of nosocomial infections.

"The study is really a pre-test of what is hoped will become a nationwide project to determine the effectiveness of infection control programs," Dr. McGowan said. "If retrospective chart review is shown here at Grady to have validity in identifying such infections, then the technique will be used by the CDC in a study of infection control programs throughout the country."

Under the program, called SENIC (Study on the Efficacy of Nosocomial Infection Control), seven nurses have been hired for five months, through a grant from CDC to Emory, to collect data on infections. Following this, a separate team will review the medical records at Grady Memorial and compare the results with data obtained by the nurses' infection surveillance methods, which, Dr. McGowan said, will help establish how close retrospective chart review can come to the effectiveness of the method currently in use in the Grady program.

"Grady has had a professionally staffed infection control program since 1972 and a fulltime epidemologist since 1973," Dr. McGowan noted, "and I'm sure this demonstrated commitment to do all that we can to prevent nosocomial infection problems had much to do with CDC selecting our hospital for the study. We're certainly pleased it did, as the study will eventually provide us a more expanded information base from which to work."

Results from this double-blind study were considered very encouraging.

Dramatic Response of Surface Contact Dermatitis to New Parenteral Corticosteriod-Betamethasone Sodium Phosphate

GLENN E. McCORMICK, M.D., *Decatur**

ORMSBY'S DEFINITION of dermatitis venenata, which is probably the most common of the eczematous diseases, is still classic: "an acute inflammation of the skin caused by external application of various substances of animal, vegetable, or chemical nature, characterized by redness and swelling, frequently vesicles and bullae, and accompanied by sensations of itching and burning."[1] When the symptoms and signs are severe and persistent, the effects of contact dermatitis can be physically and emotionally devastating to affected patients.

When pain and itching become intractable to conservative forms of therapy, more vigorous action must be taken. Short courses of corticosteroid therapy have been found highly beneficial to patients in whom there are no contraindications to steroid therapy and whose discomfort is severe. We prefer to employ the intramuscular route of administration in such patients, since dosage can be controlled very well; one or two injections are almost always sufficient to at least reverse the course of the disease if not suppress it completely. Patients are minimally inconvenienced and are exposed to only a very slight risk of side effects.

Betamethasone, one of the fluorinated prednisolone derivatives, has just been made available for intramuscular or intravenous injection.† The purpose of this paper is to report on a study of this new compound compared with placebo in patients with moderately severe to severe contact dermatitis.

Methods and Materials

The study was carried out in classically double-blind fashion, with patients admitted randomly and assigned to one or the other of the coded treatments. Patients were excluded if they had previously been given a corticosteroid for this condition or if any other pathology required treatment with antihistamines or topical/systemic corticosteroids or antibiotics. All of the usual corticosteroid contraindications and precautions were observed.

Selection was made on the basis of the investigator's judgment that each patient's dermatitis was severe or moderately severe and required systemic corticosteroid therapy. To comply with these criteria, acceptable patients had to have at least one sign or symptom rated "severe" and their overall condition rated "moderate" or "severe."

Upon entrance to the study, each patient's demography and history were recorded, then his/her dermatitis evaluated as follows:

Signs and Symptoms
- inflammation
- vesiculation
- pruritus
- exudation
- crusting
- excoriations
- burning
- overall (global) condition

Drug Effect (patient and physician opinion)

Onset of Relief (patient opinion)

Side Effects

Overall condition and signs and symptoms were rated on a 1 to 4 point scale, corresponding to *none, mild, moderate,* and *severe.* Drug effect was evaluated qualitatively by a strictly observed set of definitions, i.e., for a consideration of an *excellent*

* 755 Columbia Dr., Decatur, Ga. 30030.
† Celestone® (betamethasone sodium phosphate), Schering Corporation, Kenilworth, New Jersey.

rating, there had to be prompt ($\leq$ 24 hr) onset of effect and marked to complete clinical control of the dermatitis; *good* meant either less prompt onset ($>$ 24 hr) plus marked to complete control or prompt onset but only moderate control; *fair* meant delayed onset and moderate control; while *poor* indicated little or no effect.

Having established eligibility, each patient received a 1 ml intramuscular injection of betamethasone sodium phosphate (4.0 mg/ml) or placebo. In addition, all patients were treated topically with a bland non-medicated cream. Compresses containing Burow's solution were permitted as were any allowable medications for intercurrent illnesses, such as tranquilizers, insulin, or digitalis, but these were to be maintained on a constant dosage schedule during the trial period. No initiation of other therapy was permitted once the study began unless an emergency arose. In such an event the patient had to be dropped from the study.

All patients were seen 24 hours later (at which time a second injection could be given if warranted) and again at 48 hours, if necessary.

Results

A total of 70 patients with contact dermatitis entered the study, of whom 67 provided analyzable data. (Data for three patients were eliminated from analysis because of protocol violations.) The cohort consisted of 21 males and 46 females, from 1 to over 60 years old. Included in the total were 20 patients with dermatitis due to rhus plant contact, i.e., poison ivy, oak, or sumac; the remaining 47 had dermatitis resulting from exposure to various other irritants. The drug and placebo groups were well matched with respect to the several baseline characteristics summarized in Table 1. Since many patients were not given a second injection and were seen only 24 hours later, only the results for that first follow-up evaluation are presented here.

TABLE 1

INITIAL COMPARABILITY OF TREATMENT GROUPS

Variable	Betamethasone Phosphate (n = 33) No.	%*	Placebo (n = 34) No.	%*
Age (years)				
1-10	3	9.1	3	8.9
11-30	16	48.5	20	58.8
31-50	8	24.2	9	26.5
51-60	2	6.1	1	2.9
> 60	4	12.1	1	2.9
Race				
Caucasian	30	90.9	34	100.0
Negro	3	9.1	0	—
Duration of primary diagnosis (days)				
1-2	11	33.3	13	38.2
3-4	12	36.4	12	35.3
5-7	10	30.3	9	26.5
Disease state				
Exacerbating rapidly	22	66.6	22	64.7
Exacerbating slowly	10	30.3	10	29.4
Stable	1	3.1	2	5.9

* Decimals rounded to equal 100%.

All comparisons clearly favored betamethasone phosphate. Twenty-five of the 33 patients in the active treatment group (73 per cent) claimed they had prompt relief, compared to 10 of 34 (29 per cent) in the placebo group. The patients' quantification of this response, in terms of how many hours it took until relief was noticeable, is illustrated in Figures 1 and 2. The former shows the results for patients with contact dermatitis excluding rhus cases and the latter, for those with rhus dermatitis only. Extremely prompt relief ($<$ 3 hr) was claimed by three-fifths and four-fifths of the patients with non-rhus and rhus dermatitis, respectively, receiving betamethasone. Comparative proportions in the placebo group were one-tenth or less. Differences between the

TABLE 2

CLINICAL RESPONSE OF CONTACT DERMATITIS TO BETAMETHASONE PHOSPHATE AND PLACEBO INJECTIONS

Assessment	Mean Drug Scores* Initial	24 hr.†	Difference	Mean Placebo Scores* Initial	24 hr.†	Difference	Significance P=
Inflammation	3.50	2.35	1.15	3.45	2.70	0.75	0.005
Vesiculation	2.97	1.84	1.13	2.67	2.46	0.21	0.001
Pruritus	3.53	2.17	1.36	3.36	2.65	0.71	0.001
Exudation	2.41	1.53	0.88	2.33	2.21	0.12	0.001
Crusting	2.29	1.30	0.99	2.33	1.48	0.85	N.S.
Excoriations	2.44	1.40	1.04	2.06	1.83	0.23	0.01
Burning	3.03	1.84	1.19	3.18	2.34	0.84	0.002
Overall evaluation	3.26	2.31	0.95	3.12	2.81	0.31	0.001

* Rated on scale of 1 = none, 2 = slight, 3 = moderate, 4 = severe.
† Adjusted means.

Figure 1
Onset of Relief in 47 Patients with Contact Dermatitis (Excluding Rhus)

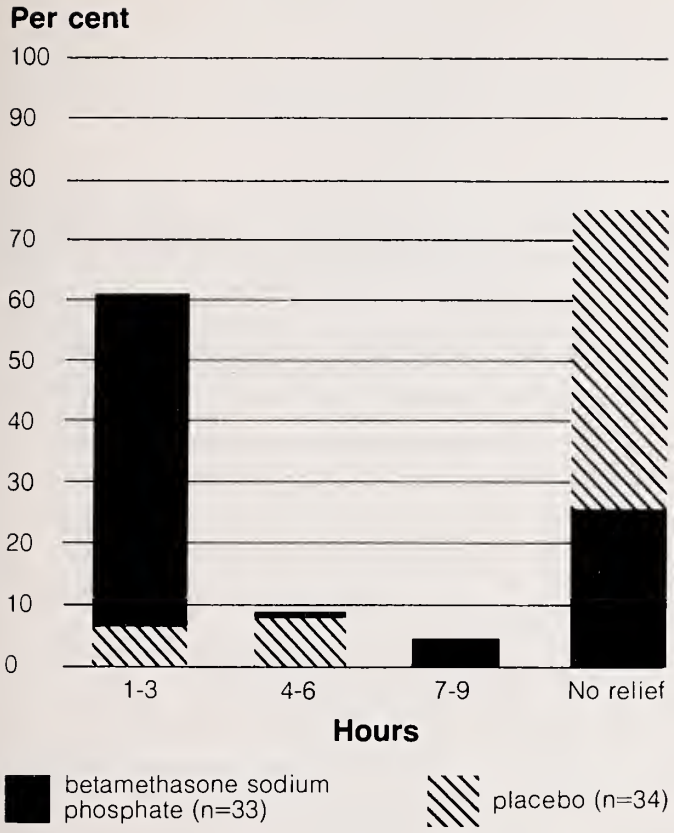
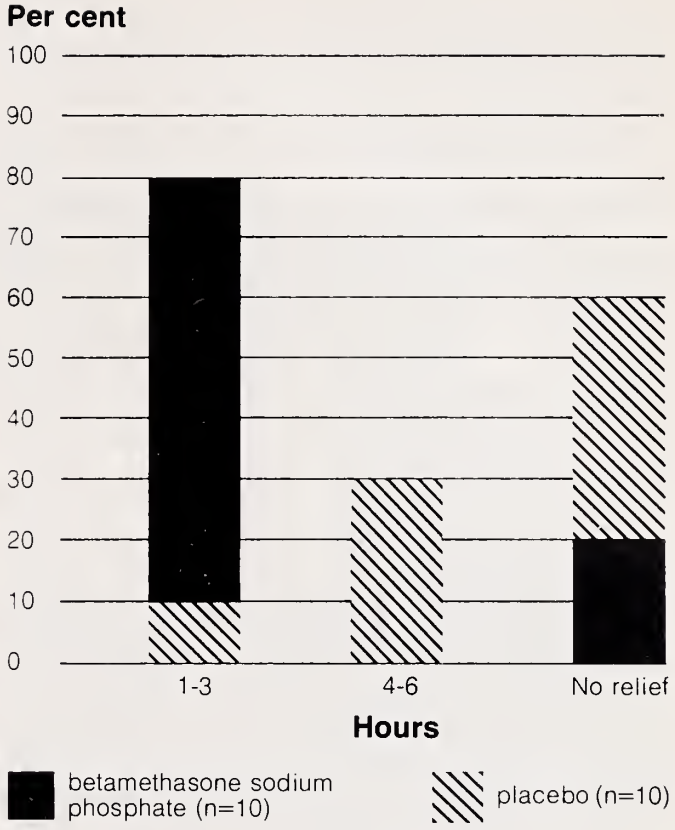


Figure 2
Onset of Relief in 20 Patients with Rhus Dermatitis



groups for time until onset of relief were highly significant ($p < .001$, Fisher's Exact test).

The response of the evaluated signs and symptoms for all patients as well as the evaluation of their overall condition are shown in Table 2. The covariance method was used for the statistical analysis of these data, with the baseline (pre-drug) ratings serving as the covariate. Patients receiving betamethasone phosphate responded significantly better than those in the placebo group for every factor assessed except for the sign crusting.

Twenty-seven of the patients in the betamethasone phosphate group (82 per cent) felt they had experienced a good or excellent effect of treatment 24 hours after injection, compared to 10 of the placebo patients (29 per cent) who had similar estimation of their response. The investigator's evaluation was almost identical: 24 good to excellent responses to drug and only nine to placebo. The condition of four patients who had received placebo was definitely worse 24 hours after injection while no patient in the drug group experienced an exacerbation (Table 3).

We were curious about the symptomatic response of the 20 patients with rhus dermatitis in this study, 10 in each group, so these data were separated from the rest and analyzed. The trends in these patients were similar to the results for the entire study population, although not every treatment difference was statistically significant (probably because of the smaller number of patients involved). Nevertheless, there were significant differences favoring the active treatment for response of vesiculation and exudation. Moreover, patients in the active treatment group

TABLE 3
PATIENT AND PHYSICIAN EVALUATION OF TREATMENT EFFECT IN BOTH GROUPS AT 24 HOURS

Rating*	Betamethasone Phosphate		Placebo	
	Physician	Patient	Physician	Patient
Excellent	6	9	1	3
Good	18	18	8	7
Fair	5	3	6	5
Poor	4	3	15	19
Worse	0	0	4	0
Totals	33	33	34	34

Definitions:

Excellent—prompt (24 hours or less) onset of effect, with marked to complete clinical control of condition.
Good—less prompt (more than 24 hours) onset of effect, but with marked to complete clinical control OR prompt (24 hours or less) onset of effect with only moderate clinical control of condition.
Fair—less prompt (more than 24 hours) onset of effect, with moderate clinical control of condition.
Poor—little or no effect.

experienced a significantly greater "drug effect" than those in the placebo group, according to patients ($p < .05$) and physician ($p < .05$). And according to the investigator's overall estimation of the treatment, those in the drug group were improved to a highly significant degree ($p < .01$).

No patient complained of any ill effects which could be traced to either treatment, nor did we observe any side effects, even in the patients who received a second injection. There was no relevant concomitant therapy in either group.

Discussion

The value of corticosteroids administered systemically to patients with severe contact dermatitis has been recognized by many authorities.[2, 3] And the utility of injectable betamethasone sodium phosphate in dermatologic states has been observed in studies here and outside the U. S.[4, 5] and in a recent review.[6]

The promising work published earlier resulted in the more definitive controlled study reported here. The design of this study took into consideration the sound medical opinion that systemic corticosteroid therapy is generally indicated in acute dermatologic disorders if symptoms are severe and disabling and the period of therapy required for suppression will be brief.[3] Thus it was decided that administration in this series of patients would be limited to one, at most two, 1 ml injections that is, a maximum of 4 to 8 mg of betamethasone sodium phosphate.

Any doubt that this regimen might be adequate was readily displaced when the double-blind coding was broken at the study's conclusion. The response in the drug group was so far superior to that in the placebo group that we now may question whether it is justified to withhold such drugs from patients who 1) are severely afflicted, 2) have not responded to more conventional modes of treatment, and 3) have no evidence of disease or history which would weigh against corticosteroid therapy. We feel secure in reaching this conclusion because of the total absence of signs of toxicity or adverse effect in any of the patients observed during this investigation.

It has since come to our attention that betamethasone sodium phosphate has been shown to be at least equal, perhaps slightly superior, to dexamethasone sodium phosphate in a multiclinic study of 124 patients with dermatologic disorders, principally those resulting from rhus contact.[7] It appears, then, that we now have at our disposal another clearly effective corticosteroid which can be used safely in appropriate dermatologic situations.

Summary and Conclusions

The sodium phosphate ester of betamethasone 4.0 mg/ml was compared with placebo in the treatment of balanced groups of patients with contact dermatitis due to a variety of irritants including rhus. Twenty-four hours after only a single 1 ml injection, the patients in the betamethasone group showed the effects of dramatic response to treatment. There were clinically and statistically significant differences favoring the drug for six of the seven symptoms assessed, for overall response, for time of onset of relief, and for patient and physician evaluation of treatment effects.

That a response of this magnitude could be accomplished within 24 to 48 hours and without a single complaint in any patient was considered very encouraging. It is suggested that this use of corticosteroid therapy has an excellent therapeutic rationale and that the new betamethasone sodium phosphate formulation for injection is highly effective and safe when used under the conditions described in this report. ■

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A timely discussion by an experienced pediatrician.

Critical Issues Facing Teenagers: Alcohol, Smoking and Drug Abuse

PRESTON D. ELLINGTON, M.D., *Gracewood**

THE MOST FREQUENT question asked of me is: WHY?

To approach the answer to this question I believe we must first answer another question first: How is it possible that these critical issues are facing our teenagers and young adults today?

When a man turns to me and asks: "Who is this teenager?" I answer him, saying,

He is an individual in "no-man's land" . . . neither a child nor an adult.
He is rebellious and resents authority and regimentation.
He is temperamental.
He is full of unbridled emotions.
He is attentive and full of curiosity.
He is tender-hearted and full of kindness.
He is eager to learn and the "world" no longer ends at the city limits.
He wants to be loved and accepted.

He is all these things and many more at all times, tinged with a little bit of the philosophy that: "Be willing to try anything once, or twice, or even more times" and "Anything that makes you feel good can't be all bad."

This is this teenager.

Now, let's take this teenager and stand him in the midst of our modern day society.

I think to fully understand our society of today we must first take a look and see what has happened in the past 25 or so years.

Adult Environment Vanishes

The child's environment was at that time an "adult" environment and the child was reared and educated by adults . . . his parents, relatives, and neighbors. Families were larger, not only more children, but most importantly, more adults. Those relatives, grandparents, uncles, aunts, and cousins not living within the same household, at least lived next door or on the same street. These were interesting adults and had a great deal to contribute to the child's education. They knew all about the child . . . where he was going, when he was coming back, why he wasn't in church last Sunday, who was his companion, etc. The neighbors were interested. They contributed a great deal to his learning, a great deal of common sense. If he played hookey from school, everyone knew about it. The whole neighborhood was his playground. He played ball in any yard on the street. Let him try it today.

The father was the undisputed head of the household, and he had available to him the sage advice and counsel of his elders.

Discipline was just but strict . . . infractions meant a trip behind the woodshed. Discipline was not the "permissive expression" sort of discipline that we have today; afraid that strict discipline might warp a child's personality. At that time "something else" was warped instead. The child was an integral part of the "adult" world but was permitted and encouraged to be a child.

Today.

Today we live as a split-level family. Parents no longer rear the child. There is no longer the time or the opportunity to educate his child. This has now been relegated to another segment of our modern-day society . . . his peers.

The teenager's environment today is a teenager's world and he seeks and receives his education from those of his own age, no longer the adult. The family today fast approaches one of a matriarchy. The

* Director of the Evaluation Center at Gracewood State School and Hospital, Gracewood, Ga. 30812. Dr. Ellington is a former delegate to the American Medical Association.

sage advice and counsel of the grandparents, the humor and comfort of the uncles and aunts, and the antics and comradeship of cousins is missing today.

The neighborhood consists of a street of houses all very much alike and inhabited by "strangers." The child knows only that these "strangers" leave him alone and he doesn't bother them. He only knows that "they" leave for work in the mornings, return in the afternoons, mow the lawn, have a cocktail before dinner, watch TV and then to bed.

His playground today is an asphalt jungle, scheduled and strictly organized. His childhood is one highly regimented:

Ballet . . . with his peers
Music lessons . . . with his peers
Gym . . . with his peers
Brownies, Cub Scouts, Boy Scouts, Girl Scouts, Boys Clubs, Girls Clubs, Art Classes, Girls Camps, Boys Camps, Day Camps, . . . with his peers.

Peer Pressure

The teenager today knows that if he's going anywhere in life that he has to hitch a ride somewhere. So he turns to his peers, his group which determines his values and accepts him as one of their own . . . but he must conform to the mores of the group. He is much more influenced by the group than by his parents or other adults. Remember now this teenager . . . as we have described him and his philosophy now placed in this environment which we have created for him . . . and the group decides that experimenting with drugs is "in." He may at first refuse to participate in such activities . . . and maybe even the second time when offered a drink of whiskey or a marijuana cigarette . . . but because of the pressure of wanting to be a part of the group and accepted by the group and since he has no place else to go, you can be sure that he will sooner or later say "Alright, just this one time."

And then there is a second time
and a third time . . .

Now there is more to it than just this. Let's explore another facet of our society which bears on our initial questions.

This facet is in the area of drugs.

The drug industry as such is a relatively young industry. Prior to World War II, there were few specific drugs, in fact, the physician of the day could carry in his little black bag a sample of just about every useful drug of the day. Today there are so many drugs available that it is an utter impossibility for a physician to know all about the drugs. In fact, most every drug store in Richmond County stocks on its shelves anywhere from 20,000 to 40,000 drugs. The miracle drugs of today will be forgotten tomorrow. The miracle drugs of tomorrow have not even been thought of yet.

Drug Oriented World

Let's see what else the teenager sees today.

Do you have any idea how large a pile 3,000 tons of aspirin would make? Would it fill a large room? Cover a football field?

I have no conception whatsoever. But that is how much aspirin you and I as Americans took last year.

We took 700,000 pounds of meprobamate (a tranquilizer) last year.

We took 10 billion sleeping capsules and stimulants. Every day, 365 days a year, drug abusers spend $750,000 to $1 million for illicit drugs in New York City alone. Can you imagine now what goes through a teenager's mind? He sees the "adult" world every morning as:

two cups of coffee and two cigarettes followed by a tranquilizer to start the day
off to work or community or club work
two cocktails before dinner, a diet and stimulant pill
TV all evening
a night-cap
a sleeping pill at bedtime
two aspirins the next morning
two cups of coffee and two cigarettes followed by a tranquilizer to start the day . . .

I feel sure that with this staggering number of drugs available today, whether obtained on prescription or illegally, the astounding common usage of drugs, whether on the advice of a physician or as is frequently done . . . self-medication . . . with drugs borrowed from a neighbor or a friend or bought "across the counter" that all this must surely have some influence on the teenager.

I'm sure that at times he must think that if this is what is expected of me as an adult I better start early so that I can get conditioned to all this. I feel sure that all this in some way . . . whether directly or indirectly, intentionally or unintentionally . . . must start some teenagers on the road to drug experimentation and then drug abuse. The average medicine cabinet contains some 22 different drugs . . . commonly, barbiturates ("sleeping") pills, amphetamines ("diet" pills, stimulants) and tranquilizers. So it isn't difficult for the teenager with such a readily available source of drugs.

It has been commented that there is probably no major school campus in this country on which there is not some degree of drug abuse. Estimates have ranged as high as 40 per cent of the student body on some campuses use either occasionally or frequently. The amphetamines (stimulants) and the barbiturates are apparently the more common drugs used on high

school campuses although marijuana has made its appearance on some. These drugs are used for the stimulating effects and when used with alcohol the effects are enhanced considerably. These drugs when used with any regularity, without medical supervision, can be dangerous. When used indiscriminately by teenagers these drugs tend to lose their ability to produce the desired effects and then the user must either increase his dosage (and one youngster was reported to have been taking as many as 40 "pep" pills a day to get the desired "high" effect) or he must "graduate" to a stronger drug or a combination of drugs, including alcohol to get "high."

These "graduate" drugs may be marijuana, LSD, narcotics, including heroin. And this teenager is now well along the road to the empty life of the drug addict. The return trip may be very difficult and in too many instances it may be impossible. For many youngsters this will be a one way trip. The life of the abuser is an empty life.

He is a social outcast

He is frequently rejected by family and friends

He is susceptible to many diseases and illnesses.

His one and only goal in life is to get the money for his next "fix" . . . through thievery or prostitution.

It isn't very difficult for us now to imagine what further critical issues face this teenager at this stage in his life what might have started out as an apparently "innocent" experiment as a member of his peerage . . . which for him now no longer exists. For now he has a new peerage, made up of those like himself, but not of his own choices but by necessity.

Smoking Begins Early

Let us now examine another crisis that faces the teenager . . . smoking. As far as is known from actual data, few children smoke before the age of 12, probably less than five per cent of the boys and less than one per cent of the girls. From age 12 on, however, there is a fairly regular increase in the prevalence of smoking. At the 12th grade level, between 40 to 55 per cent of teenagers have been found to be smokers. It is estimated that 10 per cent of later smokers "develop the habit with some degree of regularity" before their teens and at least 65 per cent during their high school years. It seems then that the years from the early teens to the ages of 18-20 are significant years in exposing people to their first smoking experiences.

It is conceivable that increased public attention to possible hazards of smoking within the last few years has led to some decrease in the number of smokers.

Smoking appears to be not one behavior but a range of psychologically diverse behaviors each of which may be induced by a different combination of factors and may serve different needs. Social stimulation appears to play a major role in a young person's early and first experiments with smoking. And there is suggestive evidence that early smoking may be linked with self-esteem and status needs among the teenagers' peers.

The "Original" Drug

Ethyl alcohol, by all odds, must have been one of the first drugs recognized by ancient man. It is formed readily in nature as a result of yeast fermentation of carbohydrate plant and fruit juices, and references to wine, beer, mead, and other alcoholic beverages appear in the earliest historical records. Alcohol is in the category of an "over-the-counter" drug and, like aspirin, requires no prescription. The number of adult drinkers in the United States is assumed to be about 80 million, and the number of alcoholics is assumed to be nearly 5 million.

It has been stated authoritatively that the average American has tasted alcoholic beverages by the time he is 10 years old. And as many as 50 to 85 per cent of American high school students say they drink at least occasionally.

The addictive tendency of alcohol is not comparable to that of morphine and its derivatives, but it is high enough. No one really knows the dimensions of alcoholism in this country; in spite of the fact that the drug has been around since the dawn of history and that experience with it has been intense in every part of the world, there is much about drinking that is not understood at all.

Although the "adult" world must accept the responsibility for having created these critical issues, the teenage world must accept the responsibility or the manner in which it faces and copes with these critical issues. I am confident that most of these youngsters are outstanding, clean-cut, confident, and respectable young Americans, eager to get on with the job of becoming responsible adults. ■

Abdominal Pain With Right Lower Quadrant Calculi

JOHN W. UFEMA, M.D. *and* VAN S. COLEMAN, M.D., *Atlanta**

DR. VAN COLEMAN: This case is a 68-year-old female who presented to us with the problem of abdominal pain. Some symptoms had been present for some months, but recently the abdomen became more painful. Dr. Ufema, would you discuss this patient's films?

Dr. John Ufema: Our initial study is a supine abdominal examination. The gas pattern is not pathologic. There is no evidence of bowel dilatation or obstruction. Two calcific areas are identified in the right lower quadrant. The larger of the two is about 14 mm. in diameter and appears to be faceted and laminated. The smaller calcification is less well seen. It is about 8 mm. in size and is barely identifiable over the right sacroiliac joint (Figure 1). A middle age patient with chronic abdominal pain always raises the question of gallbladder disease. Though these calculi are somewhat lower than the usual gallbladder position, cholecystitis is probably the first entity that should be investigated. The faceted and laminated configuration is entirely consistent with this diagnosis. The somewhat atypical position might even be associated at times with a hydropic gallbladder, but I see no evidence of soft tissue mass or mass effect with bowel displacement to indicate this. Oral cholecystography would be my first step in such a patient if the pain was not associated with a surgical abdomen. If surgery were imminent an intravenous cholangiogram might be useful in pre-operative evaluation.

Dr. Coleman: These densities were present on a previous study in 1968. They were described as somewhat smaller in size, and appeared higher within the right mid abdomen.

Dr. Ufema: Once again, the long term presence of these calculi is not inconsistent with gallbladder disease, but I might also mention some other entities that might cause such a picture.



FIGURE 1

Supine radiograph of the abdomen demonstrating two calcific densities in the right lower quadrant. One is above the sacroiliac joint and is well defined, the second overlies the right sacroiliac joint and is poorly defined.

Appendicoliths are another cause of abdominal calculi that might be associated with pain. Calcification of mesenteric nodes would not likely cause pain, and they are not lamellated. Calcification within diverticula might be considered, as might enteroliths. Enterolith formation within the bowel lumen proper is seen in partial obstruction, and the symptomatology would be that due to the obstruction.

I think that a valid point to be made with this type of problem is that the anatomic location of calculi should be pursued at the time of their discovery. Of course, the evaluation of these patients

* From a weekly X-ray Conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material was edited by Drs. J. L. Clements and H. S. Weens.

depends somewhat on age. The continuing controversy regarding the significance of gallstones is well documented in the literature. There is evidence, however, that appendicoliths also are of considerable concern. When followed, these calculi enlarge, and if the patient lives long enough, obstruction of the appendix will almost surely occur. For this reason, some feel that removal is indicated, particularly in younger patients.

Dr. Coleman: The patient went to laparotomy, at which time a grossly inflamed, enlarged appendix was removed with two fecoliths within the lumen. Figure 2 is a radiograph of the operative specimen.

Discussion

Many calcifications within the abdomen are significant. The presence of a discrete calculus is an indication for further radiological work-up. The specific anatomic location of such stones is of importance even in the absence of acute symptoms. The presence of a gastrointestinal calculus in a child is usually adequate indicative for removal. Appendicoliths in particular are associated with probable eventual appendicitis with a high incidence of early and sometimes inapparent perforation.

Gallstones commonly move about somewhat within the abdomen, but the appendix is similarly not fixed in position. Thus appendicoliths can be somewhat mobile, as seen in the present case. Differential diagnosis commonly includes ectopic gallstone, enterolith in a Meckel's diverticulum, cecal diverticulum, or regional enteritis with partial obstruction. The most informative radiologic study is most commonly barium enema. ■



FIGURE 2

Radiograph of the excised acutely inflamed appendix and the two appendicoliths which were removed from the lumen.

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WORKSHOPS TRAIN PHYSICIANS AND ASSISTANTS IN MEDICAL AUDIT PROCEDURE

Patient Care Evaluation Workshops are now being conducted around the state by MAG's Quality Assurance Project. The workshops use lectures, demonstrations and simulated exercises to train physicians and medical record specialists in the Performance Evaluation Procedure (PEP) of the Joint Commission on Accreditation of Hospitals. The retrospective medical audit procedure assesses patterns of patient care and shows the need for continuing education linked with this patient care.

The workshops for physicians and patient care evaluation committee assistants have been made possible through a grant from the Georgia Regional Medical Program.

The first of eight workshops was held in Rome, October 29-30 at Floyd Hospital. Attending were some 25 representatives from the medical staff, medical record and nursing departments of participating hospitals. On the first day, John I. Dickinson, M.D. of Rome assisted the participants in criteria setting, and data analysis and action for cholecystectomy. The second day for committee assistants only was devoted to data retrieval and display.

The second workshop was held at the Medical Center of Central Georgia in Columbus on November 19-20. Using a format similar to that of the first workshop, Edward K. Howard, M.D. of Columbus, led the group in discussion on cholecystectomy and acute myocardial infarction.

A tentative schedule for additional workshops is as follows:

Athens	January 14-15
Albany	February 11-12
Augusta	March 10-12
Savannah	April 7-8
S.E. Georgia	May 5-6
Valdosta/Thomasville	June 2-3

The schedule was set up on the basis of response to a questionnaire mailed to Georgia hospitals in September. Anyone interested in a program locally is encouraged to contact Sybil Wells, Project Director, Quality Assurance Project, Medical Association of Georgia, Research and Development, 938 Peachtree St., N.E., Atlanta, Georgia 30309. Telephone (404) 875-5546.

editorials
editorials
editorials

Is Christmas Merry? Is Christmas "Bah, Humbug" or "God Bless Us Every One"?

ANY MEMBER OF THE HELPING professions is under some pressure to view the "holiday season" with a somewhat jaundiced eye. The innumerable messages sent by our culture say that this is a time when one must be happy and rejoice with the ones you love, dissolved in a warm glow of satisfied contentment. For those who do not have families or whose family life leaves a lot to be desired the reality is totally different. Most of the year they may be able to live with that painful reality. But when the demand is laid upon them to live up to the image they are supposed to live up to—the pressures get very great indeed. And therefore "Merry" Christmas for doctors, psychiatrists, counsellors, and clergy is a time of increased strain in dealing with depression, illnesses both real and psychosomatic, and a special group of assorted ills that flesh is heir to.

Is the point of the title clear? Is the holiday season to be greeted with Scrooge and his "Bah, Humbug," or with Tiny Tim and his, "God bless us every one"? My point is that if the unreal pressures and the false expectations can be reduced to reality, it can be a blessed time.

The Christmas story is one that wins the hearts of a vast variety of otherwise tough and mangy characters. The journey, the lonely couple, the shepherds and the angel chorus, the wise men and the leading star, all combine to give a message to those who can hear it. It is not the commercial message of good cheer and wonderful gifts. It is not the Dickensian message of the groaning table, the glowing hearthside and good family gatherings. It is certainly not the unreal expectation that one can suddenly and magically acquire the properties of perfect spouse, perfect parent, perfect child, or perfect person. If one is a Christian, it is a tremendous message of hope for this life and the next.

Into a world exactly like ours, the great God has presumed to come—a tiny child to live and cheer and serve and save us. For *all* men and women of good will, the Christmas story is one that can shed at the very least, a warm ray of hope. In a darkness full of curses, a candle; in the gloom of despair, a ray of faith. In the middle of the bad news of this world, the good news that there is yet hope. To the depressed, the failure, the outcast, the lonely, it can simply be the news that someone cares—basically, that *God* cares enough to send the very best—not in a palace, but in a stable; not as a dominating king, but as a tiny child; not through the wisdom and perfection of scientists, but through the faith of a simple mother; not to the rich and powerful, but to strangers and shepherds.

Wherever one is, wherever one stands, there is enough in this powerful story to stir hope when hope is a rare commodity, to stir love when cynicism

and bitterness seem all powerful, to stir faith in a world sadly lacking that necessary quality.

I know not how others will decide, but as for me, Christmas does say to all of us—God bless us—and God bless us everyone.

The Very Rev. David B. Collins, S.T.M.
Dean, Cathedral of Saint Philip
2744 Peachtree Road, N.W.
Atlanta, Georgia 30305

MERGER PLAN SHOULD BRING IMPROVEMENTS TO BLUE CROSS AND BLUE SHIELD OF GEORGIA/ATLANTA

A plan of merger of Blue Cross of Georgia/Atlanta, Inc., and Blue Shield of Georgia/Atlanta, Inc., into a single corporation which will be known as Blue Cross and Blue Shield of Georgia/Atlanta, Inc., has been announced by President Fred R. Higginbotham.

In announcing the merger plan, Higginbotham said that "in the public interest, the Blue Cross Plan and the Blue Shield Plan will combine their efforts and operations to reduce administrative costs and more effectively coordinate services rendered."

The plan of merger has been approved by the respective Boards of Directors of the Blue Cross Plan and the Blue Shield Plan. "We are proceeding with the merger plan and hope to have it accomplished by January 1," Higginbotham said.

Edwin B. Peel, chairman of the board of the Blue Cross Plan, said that the new corporation will have a single board of directors composed of hospital, physician and public representatives.

"Merger of the two Plans will in no way affect the coverage, benefits or rights of members of either corporation," Peel added. "One corporation should be able to do a better job at a lower cost for our subscribers. "The public already thinks of us as a single corporation," said Peel, "since 'Blue Cross' and 'Blue Shield' are synonymous in the public mind."

Chairman of the Board of Directors of the Blue Shield Plan Charles E. Todd, M.D., said that the merger will put the Blue Cross and Blue Shield Plan in the best possible position to respond to the changing patterns of health care delivery and the economic conditions. "It is important that policies and decisions be formulated on the basis of the total health picture as opposed to dividing our interests between hospital care and physicians' services," he said.

Higginbotham cited several advantages to merger including a better policy-making environment which is more responsive to the total health care picture and public needs; simplification of administrative procedures including elimination of duplication resulting from having two corporations; and the opportunity to coordinate the development of new benefit packages designed to be more responsive to health care needs of the total population.

Although traditionally Blue Cross Plans and Blue Shield Plans have been separate corporations, the single corporation concept is not new. In the past few years, other Blue Cross and Blue Shield Plans throughout the nation have merged.

Blue Cross and Blue Shield of Georgia/Atlanta serves a 28-county area in northwest Georgia with a total enrollment of almost one-half million Georgians. Together, the Plans paid out $135 million in benefits, including payments for Medicare Part A recipients, during fiscal year 1975.

SENIOR PSYCHIATRIC RESIDENTS OFFERED TRAINING PROGRAM AT PEACHTREE AND PARKWOOD

A training program for psychiatric residents has been established at Peachtree and Parkwood Mental Health Center, 1999 Cliff Valley Way in Atlanta as announced by L. Guy Chelton, M.D., the Center's director.

As an affiliate of the Emory University School of Medicine, Peachtree and Parkwood offers senior residents an opportunity to become better acquainted with the private sector of psychiatry through a variety of programs.

August S. Yochem, M.D., director of psychiatric training at the Center, explains that residents will gain clinical experience under staff supervision that will broaden their scope of psychiatric knowledge through Peachtree and Parkwood's adult, adolescent and child psychiatric programs, alcohol treatment program and emergency psychiatric service.

Residents are assigned by Emory to Peachtree and Parkwood for a six month period and through rotation of training in the various units of the Center during that time will be involved in all areas of patient care.

Residents also will be afforded teaching and supervision experience with junior medical students from Emory. The students are rotationally assigned to Peachtree and Parkwood for their psychiatric training.

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IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Bone Scanning

JAMES H. LAROSE, M.D., EDGAR D. GRADY, M.D. *and*
THOMAS R. NOLAN, M.D., *East Point**

A SURVEY OF NINE ATLANTA area hospitals, each with over 200 beds revealed that in the years 1970 through 1972 most hospitals were performing 10-30 bone scans annually. There was a dramatic increase to 100-200 bone scans in 1973 and a continued increase to 200-500 in 1974. Although the 1975 figures are not yet complete it appears four hospitals will be over 500 and Emory University Hospital will be over 1000 bone scans.

The sudden increase in utilization of bone scans in 1973 can be attributed to the introduction of ^{99m}Tc-polyphosphate in July 1972. Two previous radiopharmaceuticals had been used, Strontium-85 and Fluorine-18. The beta particle radiation dosage from ^{85}Sr was so high that the Atomic Energy Commission would allow its use only in cancer patients or in patients with a strong likelihood of cancer. Another detriment to ^{85}Sr was its slow, colonic excretion necessitating cleansing enemas and a four to five day delay in scanning. Although ^{18}F was excreted quickly via the urinary tract which obviated the enemas and the delay in scanning, it had a high cost and a mere two hour half-life. Since the only source of intravenous ^{18}F was in California, only cities with direct air routes to San Francisco could hope to obtain it. Several times we had to cancel our patients anyway due to "shipping difficulties." We then attempted to obtain non-pyrogen free material from the Georgia Tech Reactor and give the radionuclide orally but this often resulted in a large accumulation of the tracer in the stomach which obscured uptake in the lower thoracic-upper lumbar spine.

Use of "Isotope Soap"

^{99m}Tc-polyphosphate, which is affectionately known as "isotope soap," exchanges for the phosphate portion of the hydroxyapatite crystal in bone. It comes in kit form and can be prepared on demand from the readily available ^{99m}Tc-pertechnetate. It has the advantage of rapid urinary excretion of the unexchanged tracer and a six hour half-life. Scanning of the torso or whole body is performed at three hours post injection and takes 30-60 minutes depending on the equipment available. The currently used radiopharmaceuticals are pyrophosphate and diphosphonate both of which are double phosphates and bind reduced technetium firmly. Their uniform small size obviates the slightly delayed excretion and poorer bone tag that was typical of the longer chained polyphosphates.

Preoperative bone scans are encouraged for breast and prostate carcinoma since detection of obvious osseous metastases will change the management and surgical approach to these diseases. Serial postoperative bone scans are usually obtained not only in breast and prostate carcinomas but also in bronchogenic, colon and renal carcinomas. Most other cancers metastasize to bone so infrequently that bone scans are probably most useful in patients with clinical bone pain.

A closer look at the Atlanta hospital survey reveals several hospitals still below

* From the Departments of Nuclear Medicine and Surgery, South Fulton Hospital, 1170 Cleveland Ave., East Point, Ga. 30344. Prepared at the request of the Professional Education Committee of the Georgia Division, American Cancer Society.

200 bone scans per year. None of these hospitals have either dual probe rectilinear scanners with whole body minification or Anger cameras with a scanning table. The implication is that with proper equipment the bone scan census would increase since the patients are probably available. ■

STATEWIDE SURVEY SHOWS 50 PER CENT OF PHYSICIANS PERFORM SOME LABORATORY WORK IN OFFICE

Earlier this year, the Legislative and Medical Subcommittees of the Georgia Board of Human Resources and the staff of the Department of Human Resources were charged with conducting a survey of physicians' offices. The questionnaire, developed in meetings with the Medical Association of Georgia's Ad Hoc Committee on Laboratory Quality, was designed to determine the amount and type of laboratory work being performed in physicians' offices and whether quality control and proficiency testing are being used. The questionnaire was mailed to one-half the membership of the Medical Association of Georgia in June.

Of the 2,121 questionnaires which were mailed out, 1,076, or 50.7 per cent, were returned to the Department of Human Resources. Of these respondents, 58.8 per cent reported that they perform some type of laboratory work in their offices. The 633 physicians reporting they perform laboratory work in their offices do urinalysis (569) and hematology (474) most frequently. Other types of procedures include chemistry (241), bacteriology (210), and serology (145).

Among all physicians who reported performing laboratory work in their office, the aide is the most frequently utilized individual performing work in the office laboratory, followed by a registered nurse. Pathologists and internists were the most frequent employers of registered technologists.

Use of primary standards was the most frequently used quality control method, with 193 physicians reporting their use of them. Precalibration was done by 174 physicians; 118 used split samples, and 31 used pooled sera.

Data was also provided on participation in proficiency testing programs. State conducted proficiency testing was the most frequently utilized program with 46 physicians utilizing the service. The program of the College of American Pathologists was used by 45 physicians; that of the American Society of Internal Medicine by 15 physicians; the Center for Disease Control's program, 13 physicians; all other programs were used by 6 physicians.

Physicians in family practice, internal medicine, and internal medicine sub-specialties led in total number of physicians as well as in number of physicians who utilize office laboratories. Family practice had 193 physicians who do laboratory work; of these, 29 participate in a proficiency testing program. There were 177 physicians in internal medicine and internal medicine subspecialties who do laboratory work; of these, 41 participate in a proficiency testing program.

Results of the survey are of particular interest to MAG's Ad Hoc Committee on Laboratory Quality. In an effort to avoid state legislation regulating laboratories in physicians' offices, the committee has written all MAG members asking those who do laboratory work to voluntarily subscribe to a proficiency testing program. Materials on these programs were to be mailed out during November. By voluntarily increasing the number of physicians who do proficiency testing, it is hoped the Department of Human Resources will determine that Georgia physicians are willing to guarantee the quality of their work without additional legislation.

AMERICAN COLLEGE OF SURGEONS SELECTS MCG RESIDENT AS COMPETITION WINNER

A Medical College of Georgia assistant resident has won top honors in the recent competition for surgical residents in various training programs within the state sponsored by the Georgia Chapter of the American College of Surgeons.

Eric Segerberg, M.D. was presented the $200 award after delivering his paper, "Alkaline Secretions and Mucosal Resistance in Development of Peptic Ulcer in the Dog," at a November 21, 1975 program held in conjunction with MAG's Scientific Assembly in Atlanta.

Other residents whose papers were selected for entrance into the competition included: Ellis Evans, M.D., assistant resident at MCG, "Diagnosis, Management, Treatment, and Local Assessment in Central Georgia of Snake Bite"; Robert Cowgill, M.D., chief resident at Georgia Baptist Hospital, "Traumatic Hepato-Portal Arterial Venous Fistula with Ascites"; Stephen M. Barnett, M.D., assistant resident in surgery with the Emory-Grady program, "Pseudomembranous Enterocolitis—A Difficult Clinical Problem"; and Jack Sorg, M.D., assistant resident at Piedmont Hospital, "Hyperalimentation in a Community Hospital."

Hospital Authorities in the State of Georgia

J. WINSTON HUFF, *Atlanta**

GEORGIA PHYSICIANS are often called upon to serve as members of county or municipal hospital authorities. In order to acquaint physicians within the state with the legal organization and functions of such hospital authorities, the following overview of the creation, functions, and financing of hospital authorities in Georgia is presented.

Creation and Operation

The Georgia Hospital Authorities Law[1] creates a hospital authority for each county and municipality within the state, and a second such authority for each county with a population of 100,000 or more in the 1970 or any later census. No such authority may transact business until activated by resolution of the governing body of the county or municipality in which it is located, which resolution must recite that there is a need for the hospital authority within the jurisdiction. Alternatively, any combination of counties and municipalities within the state may activate a joint authority for all such political subdivisions by concurrent resolution of the governing bodies of the counties or municipalities involved. A copy of the resolution or resolutions creating the hospital authority must be filed with the Department of Human Resources (formerly the Department of Public Health) prior to the commencement of operation of the authority.

Hospital authorities so activated by local government resolution are managed by a board of trustees consisting of from five to nine members residing in the city or county creating the authority (except in the case of joint authorities, which may have as many as 15 members who need not be residents of any participating city or county if they meet other residency requirements). The initial board members are appointed to staggered terms by the governing body of the city or county by which the authority is activated. Following the initial terms, selection of authority members (except for certain authorities in existence prior to 1964) is made by the board itself from a list of persons nominated by the governing body of the county or municipality. Board members elect from their number a chairman and vice-chairman, and may delegate the powers and duties of the authority to the agents, officers, and employees of the authority. Board members are to be reimbursed for their expenses in serving on the board, but can receive no compensation for service.

Powers and Functions

The Hospital Authorities Law grants hospital authorities broad authorization to undertake "projects" as defined in that law:

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* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Council to the Association, Eleventh Floor, C & S National Bank Biulding, 35 Broad St., Atlanta, Ga. 30303.

> The word "project" includes the acquisition and construction of hospitals, sanitariums, dormitories, clinics, housing accommodations, nursing homes, rehabilitation centers, extended care facilities and other public health facilities for use of patients and officers and employees of any institution under the supervision and control of any hospital Authority or leased by the hospital Authority for operation by others to promote the public health needs of the community and all utilities and facilities deemed by the Authority necessary or convenient for the efficient operation thereof.[2]

In particular, hospital authorities are empowered to operate hospital facilities within the definition of the term "project," to acquire, construct, and refurbish such projects, to lease such projects it may own for operation by others (so long as the lessee is prevented from operating at a profit), and to sell any such projects which are no longer needed. The statute enumerating the powers of hospital authorities also specifically permits authorities to issue revenue anticipation certificates and generally to exercise all powers "now or hereafter possessed by private corporations performing similar functions." However, hospital authorities are not authorized to operate or construct any project for profit and must set their rates and charges for services from time to time consistent with this limitation.

In a challenge to the constitutionality of the purchase by a hospital authority of a hospital facility from a nonprofit corporation and its subsequent leasing of the facility back to that corporation, the Georgia Supreme Court has interpreted very broadly the powers granted to hospital authorities under the Hospital Authorities Law. In the case, *Bradfield v. Hospital Authority of Muscogee County*,[3] the Supreme Court held that hospital authorities may lawfully contract with private corporations to lease hospital projects to such corporations so long as the authority has retained sufficient control over the lessee to insure that no profits are realized by the lessee corporation from operation of the project. The Court ruled that leasing of the hospital to a private concern was in the public interest and within the powers of the hospital authority.

Financing of Operations and Capital Expenditures

Hospital authorities themselves have no power to tax and must depend upon revenues from fees and charges for services and Federal and State grants for operating expenses. Although hospital authorities have no powers of taxation, counties and municipalities are specifically empowered by the Hospital Authorities Law to levy ad valorem taxes of up to seven mills on property located in their jurisdictions in order to provide hospital care for their residents. The Hospital Authorities Law further permits cities and counties to enter into contracts with hospital authorities within their jurisdictions to provide for the care of their residents, which contracts may obligate the cities or counties to pay fixed annual sums to the authorities for provision of such care or may provide for annual payments equal to the cost to the authority of caring for the indigent sick of the city or county for each year.

Hospital authorities are empowered by the Hospital Authorities Law to issue and sell revenue anticipation certificates to obtain funds to acquire, construct, repair, improve, or refinance "projects." Such certificates may bear interest at a rate not to exceed nine per cent, and must mature within 40 years of issuance. Interest on the certificates is exempt from State income taxes and is generally exempt from federal income taxes.

The issuance of revenue anticipation certificates by a hospital authority must be validated by the Superior Court of the county in which the authority is located. The validation proceedings are adversary proceedings in which the questions of validity of the proposed revenue anticipation certificates and the validity and bind-

ing effect of any contract for payments to the authority by any city or county pledged to secure payments under the certificates will be determined. Any resident of the jurisdiction served by the authority may become a party in the proceedings and may appear to argue against issuance of the certificates or the validity or binding effect of any such contract. If the Superior Court enters a judgment of validation, and after favorable determination of any appeals from the judgment, the judgment becomes conclusive with respect to issuance of the certificates and validity of the contract. The Georgia Supreme Court has held that once certificates are validated, the proceeds from sale of the certificates cannot be used for a purpose which was not stated in the validation petition.[4]

Principal and interest payments on the certificates are not general obligations of the State of Georgia, the county or municipality in which the authority is located, or even the hospital authority itself, but are revenue obligations payable only from the *revenues* of the authority. Such certificates may be made payable from the general revenues of the authority or even from the income and revenues of certain designated projects.

Hospital authorities often pledge the revenues payable to them from a particular source for payment of the certificates. Typically, where the hospital authority is a party to a contract with the county or municipality in which it is located requiring that payments be made to the authority for maintenance and use of the facilities of the authority, the authority will pledge its revenues under the contract as additional security for the certificates. Thus, even though the city or county is not directly liable on the certificates, it in effect underwrites the obligations of the authority to the extent of its contractual obligation, particularly if its contract with the authority obligates it to levy a hospital tax if necessary to make payments under the contract.

Another method of securing hospital authority revenue anticipation certificates is the pledge by the authority of payments due under a lease of one or more hospital projects by the authority to a politicial subdivision or private nonprofit corporation. In the *Bradfield v. Hospital Authority of Muscogee County* case, the lease from the authority to the nonprofit corporation was so pledged as security for the sale of revenue anticipation certificates.

Under either method, if the hospital authority fails to make any payments of principal or interest due under the certificates, the certificate holders may have recourse against the party to the contract pledged for payment of the certificates. Thus, outside security, usually that of the county or municipality, is often obtained to support the issuance of the certificates.

Conclusion

Hospital authorities in Georgia have been used extensively to make quality health care facilities available to citizens of local communities throughout the State of Georgia, and the financing of such hospital facilities through the issuance of revenue anticipation certificates has proved to be a workable method of acquiring and improving such facilities. Delegation of the management of hospital authorities to separate boards of trustees, many of the members of which are physicians, has also served to increase the political independence and expertise brought to bear on problems of health care.

Physicians who have any specific questions concerning hospital authorities, their activities, and operations should consult counsel for their local hospital authorities or their personal attorneys. ■

REFERENCES

1. Ga.L. 1964, p. 499, 598, as amended, Ga. Code Ann. Chapter 88-18.
2. Ga. Code Ann. §88-1802(d).
3. 226 Ga. 575 (1970).
4. *Smith v. Hospital Authority of Hall County and City of Gainesville,* 210 Ga. 801 (1954).

I've told this before . . . .

(Ed. note: A Christmas season story of a festive family gathered together—and a slip of the tongue that got one member in trouble. J. G. McDaniel has contributed our December story. Others wishing to contribute to this page should send their material to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Doghouse

My father got into my wife's "doghouse" in the late '30s and she never let him forget it as long as he lived.

We had only two children then. Marquerite's mother and father were both dead and we spent Christmas with my mother and father as did my other brothers and sisters. We were brought up in Eastman, Georgia. One brother lived there, Tom, a veterinarian, and a sister, Erroll Methvin and her husband Edwin. They owned and ran the newspaper.

These were gala occasions. All the men liked to hunt and did most of the time. The table was laden with soul food, game and other goodies so plentiful during the yuletide seasons.

It always seemed, though, that during the hurly-burly of Christmas and the trauma of hauling presents down there and back, associated with the fact that our old home was primarily heated by fireplaces, one of the children or Marguerite developed a cold or sore throat or something. Such was the case during this particular Christmas. Our oldest daughter, then four or five years old, had a cold and cough, a little fever, just sick enough to demand pretty much all of her mother's time.

She asked me what to do and each time I suggested half an aspirin tablet, repeated every four hours and went hunting. My father suggested some honey and lemon juice and made up the concoction for her. He even put a little whiskey in it. He was a teetotaler, but a firm believer in whiskey for medicinal purposes only. Then he joined us hunting. My mother and sisters were busy with the food, cleaning the house, etc. Every time Marguerite wanted to go somewhere, the child would cry and call "Mamma . . . Mamma," in a pitiful, plaintive voice that only a sick child can do.

On the third or fourth day, my father was tired and reneged on us. Along about 10 o'clock the overseer of the Coleman cattle farm called the house and asked my Dad if he knew where Tom was. He said that he had called the hospital and old Jeff said that Tom was out hunting. He went on to relate that his big bull had gotten tangled up in some barbed wire and had cut himself pretty badly and needed sewing up. My father assured him that he would find Tom and have him out there before dinner, 12 noon. My father had some cattle and was quite sympathetic.

He got all upset when no one knew where we were hunting. He called my brother-in-law, who was trying to get out the weekly paper, and told him to go out to the "Nanny Harrell" place and see if we were there. Then he cranked up and went out to the Coffee farm. We were at neither place. Just about the time he was about to "blow a fuse," we drove up and he told Tom in no uncertain terms to get out to the Coleman farm and sew up that bull.

Marguerite had listened to all this commotion off and on for the past hour and after things had calmed down a little she said, "Grandaddy, I do not understand this. Here I have had a sick child for three days and no one is the least bit con-

cerned, but let a little something happen to an old bull and all of you men go into a tizzy."

"But Marguerite, sugar," Grandaddy answered without thinking, "you just don't understand. That is a very fine registered bull. Why, he's worth at least $700."

J. G. McDaniel, M.D.
820 W. Wesley Road, N.W.
Atlanta, Georgia 30327

HIGHLIGHTS OF EXECUTIVE COMMITTEE
November 23, 1975

MAG Services, Inc.: Voted to capitalize the new membership service corporation to handle the printing operation as approved by Council. Elected the new Board of Directors and officers of the corporation. These are: President—Earnest C. Atkins, M.D.; Secretary—J. Rhodes Haverty, M.D.; and Treasurer—Carson B. Burgstiner, M.D. The directors are David A. Wells, M.D., Fleming L. Jolley, M.D., W. Dan Jordan, M.D. Dr. Wells also was appointed proxy to vote shares of stock for the corporation.

Medical Malpractice Testimony: Received a report of David A. Wells, M.D., president, concerning his appearance before the State House Insurance Committee's Subcommittee on Medical Malpractice. Dr. Wells stated that MAG's four main points are presently being considered by the Governor's Commission on Professional Liability.

National Health Service Corps: Approved a request of the Laurens, Ocmulgee, Telfair and Southeast county medical societies for a NHSC psychiatrist for the Dublin area.

Prison Health: Established a Committee on Prison Health Care and charged it to "study and recommend ways to improve the delivery and promote the availability of health care in non-federal prisons in Georgia." The members of the new committee are: J. Rhodes Haverty, M.D., Atlanta, chairman; James E. Baugh, M.D., Milledgeville; Henry Kenneth Walker, M.D., Atlanta; Fleming L. Jolley, M.D., Atlanta; Charles Allard, M.D., Decatur; Bob R. Maughon, M.D., Columbus; and L. C. Buchanan, M.D., Decatur. Also received the report that MAG's Research and Development section has applied for a $25,000 grant through the AMA to develop techniques and standards for jails, juvenile homes and correction centers.

State Legislation:

1. Maternity Care Insurance—Received the report that the Georgia State Obstetrical-Gynecological Society supports H.B. 719 if the mandatory portion is removed. This is concurrent with the MAG position.
2. Fifth Pathway—Directed the MAG Committee on Education to study this proposal.
3. M.D. License Fees—Voted to support an increase from $10 to $25 if additional money raised can be allocated to the board of medical examiners.
4. Practicing Medicine Without License—Voted to support a legislative proposal to make this a felony.
5. Alcoholism Insurance—Voted to oppose this legislative proposal.
6. Healing Arts Advertising—Voted to support a proposal to make it illegal for anyone practicing the healing arts to advertise.

Appointments: Maternal and Infant Welfare Committee—William P. Kanto, M.D., Augusta, for the Georgia Chapter of the American Academy of Pediatrics; T. Engene Kennedy, M.D., Buford, for the Georgia Academy of Family Physicians; Billy S. Hardman, M.D., Gainesville, currently a member but selected to represent the Georgia State Obstetrical and Gynecological Society. Committee on Laboratory Quality—Steven L. Sanders, M.D., Atlanta; L. Allen McDonough, M.D., Atlanta; David Z. Kitay, M.D., Atlanta. In addition, Richard E. DeBois, M.D., of Atlanta was named as chairman of the Laboratory Quality Committee, and former chairman G. Lester Forbes, Jr., M.D., of Atlanta will remain as a member of the committee.

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NEW MEMBERS

Aguirre, Dennis M., Muscogee—I&R
Medical Center, Columbus 31902

Bailey, William M., Bibb—Act—C
671 Hemlock St., Macon 31201

Balcos, Orlando G., Upson—Act
Box 128, Doctor's Clinic, Roberta 31078

Bartlett, Glenn H., Muscogee—I&R
Medical Center, Columbus 31902

Bolen, Richard A., Muscogee—I&R
Medical Center, Columbus 31902

Castleberry, Robert P., Muscogee—S—Pd
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Caulton, Charles I., Muscogee—I&R
Medical Center, Columbus 31902

Chevres, Francisco, Whitfield-Murray—Act—Or
1401 Burleyson Dr., Dalton 30720

Davis, W. Rex, Muscogee—S—FP
Martin Army Hospital, FP Clinic, Ft. Benning 31905

Fieseler, David P., Muscogee—I&R
Medical Center, Columbus 31902

Garnett, Robert L., Muscogee—Act—R
1935 8th Avenue, Columbus 31901

Holloway, John T., Ware—Act—FP
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House, Robert O., Muscogee—I&R
Medical Center, Columbus 31902

Ingram, Chester W., Muscogee—I&R
Medical Center, Columbus 31902

Janeczko, Gregory F., Muscogee—S—Anes
Martin Army Hospital, Ft. Benning 31905

Lyle, James E., Muscogee—I&R
Medical Center, Columbus 31902

Mathias, Phil A., Muscogee—S—ObG
Martin Army Hospital, Ft. Benning 31905

McClinton, Joe D., Muscogee—I&R
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Salehbhai, Mansoor, Peach Belt—Act—Pd
212 Hospital Dr., Warner Robins 31093

Santiago, Marcelo R., Ogeechee River—Act—Su
P.O. Box 800, Claxton 30417

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Watras, Charles S., Muscogee—I&R
Medical Center, Columbus 31902

Whatley, William B., Muscogee—I&R
Medical Center, Columbus 31902

Zuniga, Willy E., Upson—Act
Wright Ave., Roberta 31078

SOCIETIES

A slate of officers picked by the Nominating Committee of the **Bibb County Medical Society** will be presented at the December 2 meeting of the group. The nominees are: Hugh F. Smisson, president; Jack F. Menendez, president-elect; Gordon Jackson, vice president; Herbert Greenwald, secretary; Cyler Garner and Patton P. Smith, delegates to the MAG.

The November meeting in **Bibb County** featured speaker/entertainer Francis M. Daves, a Decatur architect, in a program titled, "An Evening of Versatile Entertainment." Mr. Daves writes short stories and poetry, records original songs in Nashville and is an accomplished guitarist.

DeKalb County plans to meet with its Auxiliary in January to hear speaker Phillip M. Crane, Illinois Republican in the U.S. House of Representatives. Elections for new officers were scheduled for the December meeting, with the following nominated: Stanley P. Aldridge, president-elect; H. Duane Blair, vice president; Ray W. Vandiver, Charles W. McDowell, Jr., LaMar S. McGinnis and H. Duane Blair as MAG delegates. LaMar McGinnis will ascend to the office of president and Charles McDowell will finish his two-year term as secretary-treasurer.

PERSONALS

First District

Several Savannah area physicians were initiated as Fellows of the American College of Surgeons during the annual convocation in San Francisco in mid-October: **Raul S. Buelvas, Warren Upton Clary, Edward Farmer Downing, Elliott Ronald Finger, Morris A. Kugler** and **Leslie Lamar Wiles** of Savannah; **Tom Vann Willis, Jr.** of Brunswick and **Cleveland Thompson, III** of Waycross.

Third District

Walter Lloyd Hudson, Jr. of Columbus has opened

an office in Butler for the practice of pediatrics, and will maintain office hours from 9:30 a.m. to 4 p.m. on Wednesdays. Dr. Hudson is a graduate of Emory University and the Medical College of South Carolina and is a diplomat of the American Board of Pediatrics.

New Fellows of the American College of Surgeons are **Sidney Halleck Yarbrough, III** of Columbus, **James Crawford Dudley, Jr.,** of Americus and **Albert Glenn Bailey** of LaGrange.

George S. Walker of Eastman has been certified by the American Board of Internal Medicine. He was graduated from the University of Tennessee College of Medicine and is a member of the American College of Physicians.

Fifth District

Atlanta internist **Linton H. Bishop, Jr.,** has been named to Emory University's 33-member Board of Trustees, replacing **Wadley Glenn** who will become trustee-emeritus.

Dr. Bishop is an Emory alumnus and a clinical associate professor of medicine. He serves as chief of cardiology at Crawford W. Long Hospital.

Robert L. Egan, Emory radiologist and authority on mammography, was presented the Distinguished Service Award of the American Cancer Society at its House of Delegates meeting November 5. The University of Pittsburgh alumnus was cited for the fact that his "conviction that mammography could save countless lives has led to its worldwide acceptance."

Simon Krantz of Atlanta recently was honored with the Veterans Administration Distinguished Career Citation and Medal. Dr. Krantz came to the Veterans Administration Hospital in Atlanta in 1935 as the second physician specializing in the treatment of malignant diseases by radiotherapy. He is a past chief of radiology at the hospital, professor of radiology at Emory University School of Medicine and a Fellow in the American College of Radiology.

Bernard Lipman, Atlanta, has been promoted from clinical associate professor of medicine to clinical professor of medicine (cardiology) at Emory University School of Medicine.

Sixth District

F. D. Funderburg recalled 58 years of practice in Monticello and Eatonton in a feature story in the *Macon Telegraph* in mid-October.

Beverly W. Forester, Macon, chairman of the Task Force for Development of the Mercer Medical Schools was guest speaker at a banquet at the end of October to raise funds for the school.

Robert Copeland of LaGrange has been named to serve on the Health Service Agency Board of Directors for the 24-county North Central Georgia Health Service Agency.

Seventh District

Paul L. Bradley, Willard P. Carson and **Jack Gent** of Dalton have been initiated as Fellows in the American College of Surgeons, along with **Richard A. Griffin** of Cartersville.

William S. Miller of Dalton, who has been serving as an emergency room physician at Hamilton Memorial Hospital since April, is taking over the practice of **John D. Wofford.** Dr. Miller is a graduate of the West Virginia University Medical School and is a member of the American Academy of Family Physicians.

DEATHS

Orien Thomas Gower, Jr.

Cordele physician Orien Thomas Gower, Jr., died October 30, 1975. He was 62.

Dr. Gower was born in Cordele and graduated from the Medical College of Georgia. During World War II, he served as a lieutenant colonel in the U.S. Army and was awarded the Silver Star, Bronze Star, five Battle Stars and the Croix de Guerre.

Active in the community, he was a member of the Crisp County Hospital Authority, chairman of the county board of health, director of the First Federal Savings and Loan Association of Cordele, and member of the First United Methodist Church and Rotary Club.

Survivors include his widow, Mrs. Dorothy R. Gower; mother, Mrs. O. T. Gower, Sr.; two sisters, Mrs. Bruce Williams and Mrs. Jim Chappell, all of Cordele.

Samuel J. Hightower

Macon neurosurgeon Samuel J. Hightower, 44, died November 1. He was associated with Neurological Professional Association in Macon and was a member of the Northminster Presbyterian Church, Georgia Neurosurgical Society and the Elks Club.

Dr. Hightower was graduated from the Medical College of Georgia and was a member of Phi Beta Kappa, Phi Delta Theta, Phi Rho Sigma and ΑΩΑ Honor Society. His internship was served at the U.S. Naval Hospital in San Diego, California and he saw action in the Korean Conflict.

Survivors include his widow, the former Mary West of Macon; daughter, Marion Ward Hightower; three sons, Samuel James Hightower, Jr., John West Hightower and David Wright Hightower, all of Macon; mother, Mrs. Henry C. Garrison of Atlanta.

Nathan Joe Newsom

Nathan Joe Newsom, 95, who practiced medicine some 65 years, died October 10 in Sandersville after a long illness. He was a graduate of Emory University School of Medicine and did postgraduate work at Tulane Medical School in New Orleans and in New York City.

Dr. Newsom was a member of the Lions Club, Washington County Chamber of Commerce, Sandersville Baptist Church and Phi Chi medical fraternity.

He is survived by his widow, Mrs. Eugenia Adams Newsom of Sandersville; daughters, Mrs. William Rawlings, Sandersville, and Mrs. Frank Miles of Montgomery, Ala.; son, Jesse Strickland Newsom; grandchildren.

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

The American Medical Association brought the concerns of American medicine to the attention of the Congress a number of times during the season of the Harvest Moon.

At a hearing before a House Judiciary Subcommittee looking into the charge that federal agencies may be taking too much power into their own hands, the AMA testified that "although potentially inherent in many agencies, abuses have become more obvious in the health agencies during the past 10 years."

Raymond T. Holden, M.D., Chairman of the AMA Board of Trustees, said the many health programs Congress approved during this time "because of the complexity of the solutions inherent, were often mere skeletons. In its haste to provide operational programs, Congress often has allowed executive agencies and bureaus to add the flesh."

As a result, Dr. Holden said, the final program often is "unrecognizable" from what Congress had in mind. He charged there has been intentional non-conformance with Congress' intent, "an insatiable appetite for more regulation" in which the bureaucracy "runs amok by attempting to regulate any activity which touches upon, influences, or is affected by the Congressional program." The time is long overdue to put a stop to regulatory abuse, the AMA official told the Subcommittee.

Dr. Holden pointed to the Health, Education and Welfare Department's actions on Utilization Review. After withdrawing the initial proposal for hospital preadmission certification, strongly opposed by the AMA, the Department went ahead with final rules that were "equally objectionable" in requiring review of all patients within 24 hours. Dr. Holden said provisions of the basic Medicare law were "improperly invoked" and irrelevant provisions of other programs were "imperiously used" by HEW. The AMA brought suit and was successful in obtaining a preliminary injunction upheld on appeal.

Edgar T. Beddingfield, M.D., Vice Chairman of the AMA's Council on Legislation, told the Subcommittee the AMA is backing a measure to amend the Administrative Procedures Act to require agencies to follow certain procedures. The bill, introduced by Rep. Thomas Kindness (R-Ohio), calls for adequate time for comment, and expands the type of governmental actions that would come under the rule-making regulations. The bill (H.R. 10301) requires the agency to include "the rationale in accepting, rejecting, or accepting in modified form the comments received by the interested parties." Dr. Beddingfield said this is to "assure that the agency not indulge further in its practice, often utilized, of rejecting out-of-hand comments with which it does not agree. . . ." Any final rule substantially changed from its proposed form would have to go through the process as a proposed rule to allow comment, he said.

Health of Native Americans

The AMA told Congress it is time to improve the health of Indians.

"The Association believes that today, when the nation appears ready to correct some of the wrongs done the first Americans, there is an opportunity to bring the health status of the American and Alaskan Native to the level of the general population, rather than remaining decades behind."

Robert B. Hunter, M.D., a member of the AMA Board of Trustees, said the Indian Health Service "has done well with what it has, but it does not have enough." Dr. Hunter, testifying before the House Subcommittee on Indian Affairs, endorsed legislation before the House and Senate to improve health services for Indians.

In the past, increases in the budget for Indian health services have done little more than keep up with inflation, the physician told the lawmakers. "They have enabled the Service to maintain its health care system, but not to improve it." Only a few new facilities have been built or old ones modernized, Dr. Hunter noted.

Based on extensive studies by the AMA and others, Dr. Hunter said, one solution to the manpower needs must be to attract more Indians to the health professions. He supported provisions in the measures to train more Indian physicians through scholarships and in other ways.

Changes were recommended to allow employment of private health professionals on a contract basis to meet backlogs in health care services needed by Indians. An immediate construction and modernization program for health facilities was endorsed as well as provisions requiring Indian participation in planning and program operation.

He urged passage of a provision for a one-year study to investigate alcoholism and mental health among Indians.

Lobbying Regulations

Bills before Congress to impose additional regulations on lobbying activities were opposed by the AMA as "unnecessary and discriminatory."

The goal of the legislative proposals for "open government" could be defeated by the reform plans which could stifle legitimate and needed contacts of citizens and their organizations with the Government, Executive and Congress, the AMA said.

In a statement for the House Judiciary Subcommittee considering the issue, the AMA noted the multitude of federal health programs that involve communications by

physicians and their organizations with the Government. "This access is necessary in the future to assure the maximum input of the expertise and experience of the physician and of his practical concern for the individual beneficiary," the AMA said. "This input must not be subject to unnecessary regulation."

One upshot of the legislation would be to bring under federal controls great numbers of organizations and people who heretofore have not been considered lobbyists, including state and local medical organizations.

A provision of a major lobbying bill could control organizations with periodic publications which report on legislative and regulatory affairs, the AMA said. Such organizations would have the alternative of complying with the reporting and other burdens imposed by the bill, or to cease reporting on regulatory and legislative affairs of legitimate interest to members, according to the AMA statement.

Another provision could require the reporting of all members of organizations who contribute more than $100 during a year, possibly including dues. "Such a requirement would be extremely onerous and in many situations compliance would be impossible," said the AMA. "These provisions of the bill would be harsh and unfair and could serve little or no purpose except harassment."

In discouraging communications with Congress, the goal of open government would be defeated, the statement declared.

National Rural Health Week

A resolution backed by the AMA has been introduced in Congress to authorize the President to designate the week of April 4, 1976, as National Rural Health Week. The resolution, aimed at spurring Congressional and public interest in rural health problems, was introduced in the House by Rep. Ed Jones (D-Tenn.) and eight co-sponsors. A resolution is slated to be introduced in the Senate soon. Other House sponsors were Reps. Bob Bergland (D-Minn.), John Breckinridge (D-Tenn.), Tim Lee Carter, M.D. (R-Ky.), Allan Howe (D-Utah), James Jeffords (R-Vt.), Matthew McHugh (D-N.Y.), Gunn McKay (D-Utah), and Don Young (R-Alaska).

AMPAC Request

The American Medical Political Action Committee has asked the Federal Election Commission to permit political groups to solicit support or endorsement of federal candidates through communications with members without having to subject such expenditures to the disclosure requirements of the law.

Rex Kenyon, M.D., a member of the AMPAC Board of Directors, told the Commission the Elections Law approved by Congress provides that contributions or expenditures "shall not include communications by a corporation to its stockholders and their families or by a labor organization to its members and their family on any subject." Another section provides that expenditure does not include "any communication by a membership organization . . . to its members . . ."

However, Dr. Kenyon said, the Elections Commission would appear to limit the directive of Congress allowing communications on any subject to prohibit the endorsement or solicitation of support for a federal candidate or office-holder. "We believe this is unwise," he said.

Stressing that AMPAC "has no objection whatever to the full disclosure of any and all of its activities," Dr. Kenyon said AMPAC would like to assure its members "that they can participate openly and freely without fear of being in violation of unduly restrictive laws and regulations."

Medicare Reimbursement

Quick action has been urged by the House Health Subcommittee staff to block rollbacks in Medicare reimbursement rates for physicians during the current fiscal year.

Charging that the HEW Department's index for calculating reimbursement has had the "unintended and unanticipated effect" of pushing some current payment levels below those of last year, the staff said in a report that Congress will have to move quickly "in order to make it as administratively feasible as possible to modify the current situation."

The subcommittee, headed by Rep. Dan Rostenkowski (D-Ill.), voted tentative agreement on amending the index "so as to preclude any rollback of fiscal year 1976 prevailing fees below fiscal year 1975 prevailing fees."

The change was one of the major goals sought by the AMA in testimony before the Subcommittee last month. The Administration had acknowledged the problem, but refused to support legislation to correct it, merely noting that the rollback problem would not reoccur in future updates of prevailing charge screens.

In a staff document, the Ways and Means Subcommittee noted that the economic index for physicians' fees was not issued by HEW until last April, almost two and a half years since the enabling legislation was passed. Only 30 days were then allowed for comment from interested parties, a time squeeze that generated such criticism that the regulations were the subject of hearings by the Subcommittee June 12 and then last month.

"It should be pointed out that if HEW had not delayed so long in implementing the regulations, there would not have been any rollbacks in prevailing charges," the report said.

One of the major criticisms levelled at the rollback by the staff was the effect on physician acceptance of assignment under Medicare.

"It is predictable that the rollbacks will further discourage physicians from accepting assignment" and "result in an even further decrease in the assignment rate with the consequence that beneficiaries will pay an even larger proportion of their medical bills out-of-pocket," said the report.

To illustrate how the rollback operates, the report said a beneficiary or a physician who was paid $20 for an office visit in fiscal year 1975 may get only $18 in the current fiscal year 1976.

Beyond the rollback question, the staff pointed out that members of the medical profession (including the AMA) "expressed great concern over the individual indices used to make up the overall index" which was designed to gear Medicine reimbursement with rising costs of living in general. Critics contended that the indices "did not fairly represent their increases in practice expenses. In particular, the index does not allow

for the increases in malpractice insurance premiums physicians have experienced."

Edgar T. Beddingfield, M.D., Vice Chairman of the AMA's Council on Legislation told the Subcommittee last month that the physician's fee index developed by HEW was an "abuse of the regulatory process." Dr. Beddingfield urged that the economic index be repealed.

Catastrophic Approach to NHI

A catastrophic-oriented national health insurance plan has been introduced into the Senate by Russell Long (D-La.) and Abraham Ribicoff (D-Conn.).

The bill, much the same as last year's version, was co-sponsored by 11 other Senators including Senate Majority Leader Mike Mansfield (D-Mont.), Senate GOP Leader Hugh Scott of Pennsylvania, and Senator Herman Talmadge (D-Ga.), Chairman of the Finance Subcommittee on Health.

The Long-Ribicoff bill has been the dark horse challenger in the NHI picture, opposed by all of the major outside groups offering NHI programs. It is especially repugnant to labor, and has been fought by the Administration. As the bi-partison list of Long-Ribicoff sponsors indicates, however, the measure has a lot going for it in the Senate where it ranks with organized labor's Health Security Act championed by Sen. Edward Kennedy (D-Mass.) as a contender.

Long waited a long time to put in his bill this year, prompting speculation he figured NHI was a dead issue or that he had changed his mind about his bill. As it turned out, Long chose an introduction time when interest appeared to be reviving on Capitol Hill for a catastrophic approach to NHI.

Cost of the bill was put at $7 billion yearly.

The Administration held off submission of an NHI plan this year, but is almost sure to offer a plan next year similar to the Administration's old CHIP bill. The other major NHI recommendations before Congress include the American Medical Association's Comprehensive Health Care Insurance Act, Labor's bill, the American Hospital Association's plan, and the Health Insurance companies' NHI proposal.

Under the Long bill:

- All people would be covered by a catastrophic protection provision that would pay for everything above the cost of 60 days in a hospital or $2,000 in expenses.
- A uniform national benefit and eligibility structure with heavier federal contributions that would reshape the present Medicaid program and broaden it to include the "working poor."
- Private health insurance carriers would have to meet government standards to qualify for participation in the catastrophic and other federal health programs.

The catastrophic insurance could be provided by either the government through a one per cent payroll tax or through employers' own insurance plans in which case employers could receive a 50 per cent tax rebate. A separate Social Security trust fund would finance this provision.

Private Groups Better

Private health insurance organizations do a better and cheaper job of handling Medicare bills than the Social Security Administration, according to a General Accounting Office (GAO) report.

High federal pay and administrative inefficiencies were blamed for Social Security's poor showing in comparison with private organizations.

The report was sent to the House Ways and Means Committee which requested it last year. The Ways and Means Health Subcommittee will open Autumn legislative hearings soon on National Health Insurance. A major issue is whether a Social Security-financed catastrophic program should be part of NHI.

The GAO is an agency of Congress that investigates the activities of the Federal Government as a function of Congress' oversight role.

GAO compared the SSA's Bureau of Health Insurance performance and cost for 1973 with that of four contract intermediaries—Mutual of Omaha, Travelers, the Maryland Blue Cross Plan, and Hospital Service Corporation (the Chicago Blue Cross Plan).

The GAO report found that the average cost, excluding audit, of a bill processed by SSA was $12.39 compared to $7.31 for Travelers, $7.28 for Mutual, $3.81 for Chicago, and $3.55 for Maryland.

Social Security and intermediaries like Travelers and Mutual serve providers in a number of states, thus requiring field offices, and serve a higher percentage of skilled-nursing facilities, whose bills are considered more difficult to process than hospital bills, GAO said. "Such intermediaries can be expected to have higher costs than Blue Cross Plans, which primarily serve hospitals in only one state or part of a state," the report said.

GAO said it believes the Committee should allow HEW to redesignate an intermediary "when because of geographic dispersion, the provider's selection appears to inhibit efficient administration."

The report said Social Security's Administrative costs "substantially exceed the costs of Mutual and Travelers. Higher salaries and lower productivity appear to be major reasons for the higher costs of the division, which, unlike the private intermediaries, had no production standards."

Social Security "generally took longer than the private intermediaries to pay bills and make final settlements with providers. Its error rate was about average," the report asserted.

Noting that personnel costs account for about 65 per cent of an intermediary's expenses, GAO said Social Security personnel were consistently higher paid than personnel in comparable jobs with the four private intermediaries." For example, accountants and auditors at Social Security were paid $21,600 compared with an average $15,900 in the private groups. Social Security claims examiners got $11,600 compared with $7,900; registered nurses $13,600, compared with $11,700.

Social Security's annual compensation exceeded the average annual compensation of the four private intermediaries by 36 per cent for accountants and auditors, 47 per cent for claims examiners, and 16 per cent for Registered Nurses, the report said. ■

1975 YEARBOOK

SUPPLEMENT
OF THE JOURNAL OF
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1975 YEARBOOK

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AUGUST 1975

Staff Contact Guide

Questions about MAG and related activities may be directed to the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. To assure prompt replies, it is suggested that you direct the query to the individual familiar with that field. (See list below.) Thank you.

James M. Moffett
Executive Director

Subject	*Staff Contact*
Accreditation of CME	Steve Daniel
Annual Business Meeting	Sherwood Williams
Awards	Charlie Templeton
CHAMPUS	Joyce Butler
CHEC	Lowell Foster
Committee on Cancer	Lowell Foster
Communications	Charlie Templeton
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THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned and edited by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the director of the Council of the Association. Second-class postage paid at Atlanta, Georgia and additional mailing offices. Roster, $5 for members, $10 for nonmembers.

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Position		*Term Ending*
* President	David A. Wells, Dalton	1976
* President-Elect	Fleming L. Jolley, Atlanta	1976
* Immediate Past President	J. Rhodes Haverty, Atlanta	1978
Past President	C. E. Bohler, Brooklet	1977
Past President	F. W. Dowda, Atlanta	1976
* First Vice President	W. Daniel Jordan, Atlanta	1976
* Second Vice President	James H. Sullivan, Columbus	1976
* Chairman of Council	Fleming L. Jolley, Atlanta	1976
* Secretary	Earnest C. Atkins, Atlanta	1978
* Treasurer	Carson B. Burgstiner, Savannah	1978
* Speaker of the House	L. C. Buchanan, Decatur	1977
* Vice Speaker of the House	Ronald F. Galloway, Augusta	1977
* Chairman of Finance	F. G. Eldridge, Valdosta	1976
Editor, *JMAG*	Edgar Woody, Jr., Atlanta	1976

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District	*Councilor*	*Vice Councilor*	*Term Ending*
1	Albert M. Deal, Statesboro	Leon E. Curry, Metter	1976
2	J. Daniel Bateman, Albany	Frank R. Miller, Thomasville	1976
3	John H. Robinson, Americus	B. Lamar Pilcher, Warner Robins	1976
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1977
7	Don Schmidt, Cedartown	Richard A. Griffin, Cartersville	1977
8	Robert E. Perry, Jr., Brunswick	Joe C. Stubbs, Valdosta	1977
9	Harvey M. Newman, Gainesville	L. Austin Flint, Canton	1978
10	Edwin W. Allen, Jr., Milledgeville	M. A. Hubert, Athens	1978
Bibb CMS	Milton I. Johnson, Macon	Beverly B. Sanders, Macon	1978
Cobb CMS	Charles R. Underwood, Marietta	Frank W. McKinnon, Marietta	1978
DeKalb CMS	Luther M. Vinton, Avondale Estates	Stanley P. Aldridge, Decatur	1978
Floyd-Polk Chattooga CMS	John I. Dickinson, Rome	Lee H. Battle, Rome	1978
Medical Association of Atlanta	John T. Godwin, Atlanta	J. Norman Berry, Sandy Springs	1977
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	J. Harold Harrison, Atlanta	W. W. Moore, Jr., Atlanta	1976
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Richmond CMS	Ronald F. Galloway, Augusta	Henry D. Scoggins, Augusta	1978

AMA DELEGATES AND ALTERNATE DELEGATES AS OF JANUARY 1, 1975

Delegates	*Term Ending*	*Alternate Delegates*	*Term Ending*
J. W. Chambers, LaGrange	12-31-75	F. G. Eldridge, Valdosta	12-31-75
John S. Atwater, Atlanta	12-31-75	Luther M. Vinton, Avondale Estates	12-31-75
Harrison L. Rogers, Atlanta	12-31-76	C. E. Bohler, Brooklet	12-31-76
J. Dan Bateman, Albany	12-31-76	F. W. Dowda, Atlanta	12-31-76

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Delegates	*Term Ending*	*Alternate Delegates*	*Term Ending*
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FAMILY PRACTICE	GEORGIA ACADEMY OF FAMILY PHYSICIANS Wells Riley, 151 West Mill Street, Jonesboro 30236
GASTROENTEROLOGY	GEORGIA GASTROENTEROLOGIC SOCIETY E. Napier Burson, 340 Boulevard, N.E., Atlanta 30312
INTERNAL MEDICINE	GEORGIA SOCIETY OF INTERNAL MEDICINE Allan Bleich, 5675 Peachtree Dunwoody Road, N.E., Atlanta 30342 AMERICAN COLLEGE OF PHYSICIANS Edwin Evans, 340 Boulevard, N.E., Atlanta 30312
NEUROLOGY	GEORGIA NEUROLOGICAL SOCIETY Georgia R. Mushet, 1003 Chafee Avenue, Augusta 30904
NEUROSURGERY	GEORGIA NEUROSURGICAL SOCIETY Ellis B. Keener, 365 Winn Way, Decatur 30030
OB-GYN	GEORGIA STATE OBSTETRICAL-GYNECOLOGICAL SOCIETY James R. Gregory, 1109 Burleyson Drive, Dalton 30720
OPHTHALMOLOGY	GEORGIA SOCIETY OF OPHTHALMOLOGY John H. Reed, 1128 Vine Street, N.E., Gainesville 30501
ORTHOPAEDICS	GEORGIA ORTHOPAEDIC SOCIETY Milton B. Satcher, 2788 Bayard Street, East Point, Georgia 30344
PATHOLOGY	GEORGIA ASSOCIATION OF PATHOLOGISTS Robert E. DeLashmutt, 340 Boulevard, N.E., Atlanta 30312
PEDIATRICS	GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS James W. Bennett, 1467 Harper Street, Augusta 30902
PLASTIC SURGERY	GEORGIA SOCIETY OF PLASTIC SURGERY Robert W. Crowe, 3250 Howell Mill Road, N.W., Atlanta 30327
PSYCHIATRY	GEORGIA PSYCHIATRIC ASSOCIATION Joseph B. Baird, Jr., 1970 Cliff Valley Way, N.E., Atlanta 30329
PUBLIC HEALTH	GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS Elton S. Osborne, Jr., 47 Trinity Avenue, S.W., Atlanta 30334
RADIOLOGY	GEORGIA RADIOLOGICAL SOCIETY J. H. Walker Harris, Medical Center, Columbus 31906
SURGERY	GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS Frank L. Wilson, 35 Collier Road, N.W., Atlanta 30309
UROLOGY	GEORGIA UROLOGICAL ASSOCIATION Tom Florence, 340 Boulevard, N.E., Atlanta 30312

County Guide List

The following County Guide List is provided as an aid in locating a specific member physician. The first column lists the county in which he would practice; the second column indicates the number of the component county medical society in which he holds membership; the third column is the name of the component county medical society; and the fourth column gives the page number on which each component county listing begins.

County	County No.	County Medical Society	Page Number
Appling	1	Altamaha	63
Atkinson	18	Coffee	72
Bacon	72	Ware	100
Baldwin	2	Baldwin	63
Baker	23	Dougherty	75
Banks	37	Jackson-Banks	90
Barrow	3	Barrow	63
Bartow	4	Bartow	63
Ben Hill	5	Ben Hill-Irwin	63
Berrien	56	South Georgia	96
Bibb	6	Bibb	63
Bleckley	50	Ocmulgee	93
Brantley	72	Ware	100
Brooks	65	Thomas Area	98
Bryan	11	Georgia Medical Society	66
Bulloch	8	Ogeechee River	65
Burke	9	Burke	66
Butts	59	Spalding	97
Calhoun	58	Southwest Georgia	97
Camden	24	Camden-Charlton	75
Candler	8	Ogeechee River	65
Carroll	10	Carroll-Douglas-Haralson	66
Catoosa	70	Walker-Catoosa-Dade	100
Charlton	24	Camden-Charlton	75
Chatham	11	Georgia Medical Society	66
Chattahoochee	47	Muscogee	91
Chattooga	27	Floyd-Polk-Chattooga	76
Cherokee	14	Cherokee-Pickens	68
Clarke	15	Crawford W. Long	69
Clay	58	Southwest Georgia	97
Clayton	16	Clayton-Fayette	69
Clinch	56	South Georgia	96
Cobb	17	Cobb	70
Coffee	18	Coffee	72
Colquitt	19	Colquitt	72
Columbia	44	McDuffie	91
Cook	56	South Georgia	96
Coweta	20	Coweta	72
Crawford	6	Bibb	63
Crisp	26	Flint	76
Dade	70	Walker-Catoosa-Dade	100
Dawson	34	Hall	89
Decatur	21	Decatur-Seminole	72
DeKalb	22	DeKalb	72
Dodge	50	Ocmulgee	93
Dooly	26	Flint	76
Dougherty	23	Dougherty	75
Douglas	10	Carroll-Douglas-Haralson	66
Early	58	Southwest Georgia	97
Echols	56	South Georgia	96
Effingham	11	Georgia Medical Society	66
Elbert	12	Elbert	68
Emanuel	25	Emanuel	75
Evans	8	Ogeechee River	65
Fannin	7	Blue Ridge	65
Fayette	16	Clayton-Fayette	69
Floyd	27	Floyd-Polk-Chattooga	76
Forsyth	13	Chattahoochee	68
Franklin	28	Franklin-Hart	77
Fulton	29	Medical Assoc. of Atlanta	77
Gilmer	7	Blue Ridge	65
Glascock	54	Richmond	93
Glynn	30	Glynn	88
Gordon	31	Gordon	89
Grady	65	Thomas Area	98
Greene	49	Oconee Valley	93
Gwinnett	13	Chattahoochee	68
Habersham	33	Habersham	89
Hall	34	Hall	89
Hancock	49	Oconee Valley	93
Haralson	10	Carroll-Douglas-Haralson	66
Harris	45	Meriwether-Harris-Talbot	91
Hart	28	Franklin-Hart	77
Heard	68	Troup	99
Henry	59	Spalding	97
Houston	26	Peach Belt	76
Irwin	5	Ben Hill-Irwin	63
Jackson	37	Jackson-Banks	90
Jasper	2	Baldwin	63
Jeff Davis	1	Altamaha	63
Jefferson	39	Jefferson	90
Jenkins	8	Ogeechee River	65
Johnson	42	Laurens	90
Jones	6	Bibb	63
Lamar	59	Spalding	97
Lanier	56	South Georgia	96
Laurens	42	Laurens	90
Lee	23	Dougherty	90
Liberty	62	St. John's Parish	98
Lincoln	54	Richmond	93
Long	11	Georgia Medical Society	66
Lowndes	56	South Georgia	96
Lumpkin	34	Hall	89
McDuffie	44	McDuffie	91
McIntosh	11	Georgia Medical Society	66
Macon	36	Peach Belt	90
Madison	15	Crawford W. Long	69
Marion	61	Sumter	98
Meriwether	45	Meriwether-Harris-Talbot	91
Miller	58	Southwest Georgia	97
Mitchell	46	Mitchell	91
Monroe	6	Bibb	63
Montgomery	57	Southwest Georgia	97
Morgan	49	Oconee Valley	93
Murray	76	Whitfield-Murray	101
Muscogee	47	Muscogee	91
Newton	48	Newton-Rockdale	93
Oconee	15	Crawford W. Long	69
Oglethorpe	15	Crawford W. Long	69

County	County No.	County Medical Society	Page Number
Paulding	17	Cobb	70
Peach	36	Peach Belt	90
Pickens	14	Cherokee-Pickens	68
Pierce	72	Ware	100
Pike	69	Upson	99
Polk	27	Floyd-Polk-Chattooga	76
Pulaski	50	Ocmulgee	93
Putnam	2	Baldwin	63
Quitman	58	Southwest Georgia	97
Rabun	60	Stephens—Rabun	98
Randolph	53	Randolph-Stewart-Terrell	93
Richmond	54	Richmond	93
Rockdale	48	Newton-Rockdale	93
Schley	61	Sumter	98
Screven	55	Screven	96
Seminole	21	Decatur-Seminole	72
Spalding	59	Spalding	97
Stephens	60	Stephens-Rabun	98
Stewart	53	Randolph-Stewart-Terrell	93
Sumter	61	Sumter	98
Talbot	45	Meriwether-Harris-Talbot	91
Tattnall	57	Southeast Georgia	97
Taylor	61	Sumter	98
Telfair	64	Telfair	98
Terrell	53	Randolph-Stewart-Terrell	93
Thomas	65	Thomas Area	98
Tift	66	Tift	99
Toombs	57	Southeast Georgia	97
Towns	33	Habersham	89
Treutlen	57	Southeast Georgia	97
Troup	68	Troup	99
Turner	26	Flint	76
Twiggs	6	Bibb	63
Union	7	Blue Ridge	65
Upson	69	Upson	99
Walker	70	Walker-Catoosa-Dade	100
Walton	71	Walton	100
Ware	72	Ware	100
Washington	74	Washington	100
Wayne	75	Wayne	100
Webster	61	Sumter	98
Wheeler	57	Southeast Georgia	97
White	34	Hall	89
Whitfield	76	Whitfield-Murray	101
Wilcox	50	Ocmulgee	93
Wilkes	78	Wilkes	101
Wilkinson	6	Bibb	63
Worth	79	Worth	101

MAG District Societies



Explanation of Roster Information

This roster is made up of physicians whose names were forwarded to the Headquarters Office of the Medical Association of Georgia by the secretaries of the component county medical societies as being members in good standing as of June 1, 1975. Also included in this roster are the names of those physicians who are classified, according to membership status, as: 1) Active; 2) Active, Intern and Resident; 3) Active, Dues Exempt; 4) Associate; 5) Honorary; 6) Retired; and 7) Service. Only members in the first two classifications pay dues. Consult the county society secretary concerning omissions.

This roster contains two types of lists on the membership: the first is alphabetical, and the second is by county medical society. In each the following information is given: name, county medical society number, membership status and specialty on the first line; address on the second line. All city names not followed by a state name are in Georgia. The County Guide List preceding this page lists each county, the number and name of the county medical society of which it is a part, and the page on which that listing begins.

KEY TO LETTER ABBREVIATIONS

TYPES OF MEMBERSHIP

ACT	Active Member
I&R	Active, Intern and Resident
AF	Affiliate Member
A	Associate Member
DE 1	Active Member, Dues Exempt—financial hardship or illness
DE 2	Active Member, Dues Exempt—in postgraduate training
DE 4	Active Member, Dues Exempt—on temporary duty with the armed forces or equivalent
DE 5	Active Member, Dues Exempt—over 70 years of age
H	Honorary Member
R	Retired
S	Service Member
ST	Student Affiliate

SPECIALTIES OF PRACTICE

ACM	Academic Medicine
Ad	Hospital Administration
Al	Allergy
ALR	Otology, Laryngology, Rhinology
AM	Aviation Medicine
Anes	Anesthesiology
Bact	Bacteriology
C	Cardiovascular Disease
CH	College Health
CP	Clinical Pathology
D	Dermatology
E	Epidemiology
EM	Emergency Medicine
En	Endocrinology
FP	Family Practice
G	Gynecology
GE	Gastroenterology
I	Internal Medicine
Ind	Industrial Medicine
N	Neurology
NE	Nephrology
NR	Neuroradiology
NS	Neurological Surgery
OALR	Ophthalmology, Otology, Laryngology, Rhinology
Ob	Obstetrics
ObG	Obstetrics, Gynecology
On	Oncology
Oph	Ophthalmology
Or	Orthopedic Surgery
OrS	Oral Surgery
Oto	Otolaryngology
P	Psychiatry
Path	Pathology
Pd	Pediatrics
PdC	Pediatric Cardiology
PdN	Pediatric Neurology
Phar	Pharmacology
PH	Public Health
PL	Plastic Surgery
PM	Physical Medicine
PN	Psychiatry Neurology
Pr	Proctology
Pul	Pulmonary Diseases
R	Roentgenology, Radiology
Su	Surgery
TS	Thoracic Surgery
U	Urology
VS	Vascular Surgery

A

ABBOTT, DON C. 54 ACT N
1220 ELLA ST.,ANDERSON,S.C. 29621

ABBOTT, EMILE G. 48 ACT I
2121 FLAT SHOALS RD.,CONYERS 30207

ABBOTT, OSLER A. 29 DE1 SL
3037 W. PINE VALLEY RD., NW, ATLANTA 30305

ABELE, DONALD C. 54 ACT D
MED. COLLEGE OF GA., AUGUSTA 30902

ABELLERA, E. Q. 16 ACT SL
5330 WARRINGTON PL., COLLEGE PK 30349

ABEND, MELVIN N. 29 ACT SL
6063 PEACHTREE PKWY., NORCROSS 30071

ABERNATHY, A. H., III 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

ABERNATHY, ERNEST W. 29 ACT SL
157 N. MAIN ST.,JONESBORO 30236

ABOUL-KHAIR, SIDKY 54 ACT I
304 JONES AVE.,WAYNESBORO 30830

ACHECAR, FRED A. 16 ACT NS
33 S.W. UPPER RIVERDALE RD.,RIVERDAL 30274

ACHORD, JAMES L. 6 ACT I
P. O. BOX 6000, MACON 31201

ACKERMAN, ELLIOTT A. 22 ACT GR
305 WINN WAY, DECATUR 30030

ACREE, JOHN W. 34 ACT FP
HIAWASSEE 30546

ACREE, RUSSELL A. 56 ACT FP
HAHIRA 31632

ADAIR, HAROLD E. 29 ACT L
490 PEACHTREE ST., N.E., ATLANTA 30308

ADAIR, M. C. 27 ACT FP
FLOYD CO. HOSP.,ROME 30161

ADAMS, CHARLES D. 29 ACT D
34 SEVENTH ST. N. E., ATLANTA 30308

ADAMS, CHARLES P. 29 ACT SL
478 PEACHTREE ST. N. E., ATLANTA 30308

ADAMS, ELISABETH K. 29 A I
1685 MASON MILL RD,NE, ATL. 30329

ADAMS, J. FRED 36 DE5 FP
MONTEZUMA 31063

ADAMS, JOHN B, JR. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015

ADAMS, JOHN W., JR. 70 ACT PATH
HUTCHESON MEM. HOSP., FT. OGLETHORPE 30741

ADAMS, MELVIN L. 6 ACT EM
3037 MALVERN HILL DR., MACON 31208

ADAMS, THOMAS M. 36 ACT
MONTEZUMA 31063

ADAMS, WILLIE, JR. 23 ACT CBG
711 N. MONROE ST., ALBANY 31701

ADAN, ANIBAL 22 ACT ANES
P.O. BOX 33247., DECATUR 30033

ADCOCK, DAVID W. 19 ACT DR
1414 S. MAIN ST., MOULTRIE 31768

ADDISON, BENJAMIN ALFRED 30 ACT SL
2432 PARKWOOD DRIVE, BRUNSWICK 31520

ADDISON, WINNIFRED A. 34 ACT CBG
1144 VINE ST., N.E., GAINESVILLE 30501

ADERHOLT, HEWLETT EDWIN 29 ACT ANES
20 LINDEN AVE., ATLANTA 30308

ADICKES, H. F., JR. 30 ACT P
5 RETREAT PL., ST. SIMONS ISLAND 31522

ADKINS, F. T. 72 A PH
P. O. DRAWER 1110, WAYCROSS 31501

ADKINS, THOMAS E. 70 ACT FP
789 CHICKAMAUGA AVE., ROSSVILLE 30741

AGNOR, E. B. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

AGOSTAS, W. N. 54 ACT I
1021 15TH STREET, AUGUSTA 30901

AGRAZ, RODOLFO R. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001

AGRIN, ALFRED 29 A P
3916 BEECHWOOD DR., N. W., ATLANTA 30327

AGUERO, OSCAR E. 56 ACT OR
DOCTORS BLDG., VALDOSTA 31601

AGUILAR, AGUSTIN 29 ACT ANES
5662 QUEENSBOROUGH DR. N.E., ATLANTA 30328

AQUILAR, JUAN J. 42 S SL
VA CENTER, DUBLIN 31021

AGUILAR, SANTIAGO J. 2 ACT P
914 RIVERBEND DR., MILLEDGEVILLE 31061

AHMANN, PETER A. 29 ACT PD
1365 CLIFTON RD., N.E., ATLANTA 30322

AHN, YOUNG W. 29 ACT OBG
69 BUTLER ST.,S.E., ATLANTA 30303

AJOY, ANA B. 29 ACT ANES
BOX 1260 GUAYAQUIL, ECUADOR,S. AMER.

AKAMATSU, YASUYUKI 54 ACT PATH
MED. COLLEGE OF GA., AUGUSTA 30902

AKERY, EARL J. 71 ACT FP
WALTON CLINIC, MONROE 30655

AKIN, JOHN T., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

ALABANZA, F. V. 14 ACT OBG
CANTON MED. CTR., CANTON 30114

ALARCON, ALFREDO 29 ACT SL
490 PEACHTREE ST., N. E., ATLANTA 30308

ALDAY, JAMES M., JR. 34 ACT DR
650 BROAD ST., S.E., GAINESVILLE 30501

ALDEN, HERBERT S. 29 DE5 D
1293 PEACHTREE ST. N.E., ATLANTA 30309

ALDERETE, JOSEPH F. 29 S P
771 MCDONOUGH BLVD., S.E. ATLANTA 30315

ALDERMAN, EARL L. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

ALDRIDGE, STANLEY P. 22 ACT I
755 COLUMBIA DR., DECATUR 30030

ALEXANDER, G. H. 6 DE5 FP
235 MEDICAL COURT, FORSYTH 31029

ALEXANDER, HAROLD H. 29 ACT OR
650D VERNON WOODS DR.,N.E., ATLANTA 30328

ALEXANDER, J. L. 11 ACT SL
4D MEDICAL ARTS CENTER, SAVANNAH 31405

ALFERT, HAROLD J. 16 ACT U
2788 BAYARD ST.,SUITE 1D3, E POINT 30344

ALFONSO, JOSE G. 56 ACT PD
310 JANET ST., VALDOSTA 31601

ALFRED, OEWITT C., JR. 29 ACT P
80 BUTLER ST., S.E., ATLANTA 30303

ALISAGO, ANDRES J. JR. 70 ACT ANES
J.L. HUTCHESON MEM. HOSP.,FT. OGLE 30704

ALLAN, CHRISTOPHER J. 29 ACT PA
1000 JOHNSON-FERRY RD., ATLANTA 30342

ALLARD, CHARLES 22 ACT SL
755 COLUMBIA DR., DECATUR 30030

ALLEN, CALVIN H., JR. 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501

ALLEN, E. W., SR. 2 DE5 P
STATE HOSPITAL, MILLEDGEVILLE 31062

ALLEN, EDWIN W., JR. 2 ACT I
511 N. COBB ST., MILLEDGEVILLE 31061

ALLEN, H. D., JR. 2 DE5 P
MILLEDGEVILLE 31061

ALLEN, H. H. 22 DE5 FP
2343 HENDERSON MILL RD., ATLANTA 30345

ALLEN, JOHN EDWARD, JR. 29 ACT PD
1649 CLEVELAND AVE., EAST POINT 30344

ALLEN, JOHN J. 15 ACT FP
P.O. BOX 6124., ATHENS 30601

ALLEN, LANE H. 54 ACT
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ALLEN, LAWRENCE LANIER 69 ACT FP
211 THURSTON STREET, THOMASTON 30286

ALLEN, LEE T. 22 ACT U
755 COLUMBIA DR., DECATUR 30030

ALLEN, MARSHALL B., JR. 54 ACT N
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ALLEN, R. D. 10 ACT
TALLAPOOSA 30176

ALLEN, THOMAS M. 53 ACT FP
JOHNSON ST., DAWSON 31742

ALLGOOD, PIERCE 29 ACT OR
35 COLLIER RD., N.W., ATLANTA 30309

ALLMAN, FRED L. 29 ACT OR
615 PEACHTREE ST., N.E., ATLANTA 30308

ALMAND, JOSEPH M., JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240

ALONSO, JORGE P. 59 ACT ANES
604 S. 8TH ST., GRIFFIN 30223

ALONSO, KENNETH B. 16 ACT PATH
CLAYTON GENERAL HOSP., RIVERDALE 30274

ALPERIN, HERBERT 29 ACT PD
5675 PTREE-DUNWOODY RD.,N.E.,ATLANTA 30342

ALPERN, ROBERT J. 22 ACT CHLD
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

ALTHISAR, H. M. 54 ACT FP
VA HOSP., AUGUSTA 30904

ALVAREZ, ANGEL C. 47 ACT PD
7121 LULLWATER RD., COLUMBUS 31904

ALVAREZ, H. W. 2 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31061

ALVAREZ, M. L. 11 ACT PATH
1804 STILLWOOD DR., SAVANNAH 31406

ALVAREZ-MENA, SERGIO C. 2 ACT I
CENTRAL STATE HOSP., MILLEDGEVILLE 31062

AMATRIAIN, F. F. 22 ACT OBG
340 BOULEVARD, N.E., ATLANTA 30312

AMBROSE, SAMUEL S., JR. 29 ACT U
1365 CLIFTON RD., N.E., ATLANTA 30322

AMERSON, J. RICHARD 29 ACT SL
EMORY UNIVERSITY CLINIC, ATLANTA 30322

AMMONS, JOHN C. 29 S N
1670 CLAIRMONT RD., N. E., ATLANTA 30329

ANDERS, MACELYN V. 8 ACT FP
MED. DIR. GA. SOU. COLL., STATESBORO 30458

ANDERS, PATRICK L. 29 ACT OBG
2726 FELTON DRIVE, EAST POINT 30344

ANDERS, REBEKAH Y. 29 ACT FP
2726-A FELTON DR., EAST POINT 30344

ANDERSON, BENJAMIN S. JR. 27 ACT FP
P. O. BOX 508, CEDARTOWN 30125

ANDERSON, FRANK P., JR. 54 ACT PD
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902

ANDERSON, GROVER L. 29 ACT NS
4326 HARRIS VALLEY RD., N.W., ATL 30342

ANDERSON, JOHN M. 29 ACT P
490 PEACHTREE ST., N. E., ATLANTA 30308

ANDERSON, PAUL D. 47 DE4 I
MARTIN ARMY HOSP., FT. BENNING 31905

ANDERSON, ROBERT F., JR 34 ACT SL
194 GOLD ST., GAINESVILLE 30501

ANDERSON, SAMUEL A. 29 DE5 P
2300 N. VIENNA, RUSTON, LA. 71270

ANDERSON, THOMAS J., JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308

ANDERSON, WILLIAM B. 29 ACT P
1970 CLIFF VALLEY WAY, N.E. ATLANTA 30329

ANDERSON, W. R. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709

ANDRADE, J. ROBIN DE 29 ACT OR
1365 CLIFTON RD., N.E., ATLANTA 30322

ANDREWS, CHAS. R., JR. 14 ACT SL
CANTON 30114

ANDREWS, JAMES R. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901

ANDREWS, RUSSELL E. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161

ANGELL, JOHN F. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31405

ANTHONY, H.F., JR. 69 ACT R
P. O. BOX 170, THOMASTON 30286

ANTHONY, JAMES E., JR. 22 ACT SL
755 COLUMBIA DR., DECATUR 30030

ANTRDBUS, LEROY C. 2S ACT PD
495 E. CROSSVILLE RD., ROSWELL 30075

APANAY, MANDLD B. 16 ACT SL
409 ARROWHEAD BLVD., JONESBORO 30236

APPEL, SIDNEY D. 2S ACT SL
490 PEACHTREE ST., N.E., ATLANTA 30308

APPLE, DAVID F. 2S ACT GR
1938 PEACHTREE RD., N. W., ATLANTA 30309

APPLETON, BROWN C. 11 ACT EM
P.O. BOX 6688, ST. C, SAVANNAH 31405

ARANEDA-CASTILLO, E. R. 17 ACT PD
1676 MULKEY RD., AUSTELL 30001

ARANGO, VIRGILID A. 2S ACT PD
35 LINDEN AVE. NE., ATLANTA 30308

ARELLANO, BERNARD G. 23 ACT FP
507-3RD AVE., ALBANY 31701

ARIAS, RAMON A. 17 ACT PD
2404 AUSTELL RD., AUSTELL 30001

ARKIN, MURRAY C. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405

ARMSTRONG, CHARLES L. 2S ACT FP
5675 PTREE DUNWOODY N.E., ATLANTA 30342

ARMSTRONG, EDWARD S. 23 ACT I
223 THIRD AVE., ALBANY 31705

ARMSTRONG, GEORGE F., JR. 2S ACT PD
47 PEACHTREE PARK DR., N.E., ATLANTA 30309

ARMSTRONG, NATHANIEL E. 3C ACT SL
P.O. BOX 1258, BRUNSWICK 31520

ARNALL, JOHN ROBERT 36 ACT FP
PERRY 31069

ARNETT, THOMAS E. 65 ACT GBG
918 S. BROAD ST., THOMASVILLE 31792

ARNOLD, HARRY D., JR. 2S ACT CPH
1293 PEACHTREE ST. N. E., ATLANTA 30309

ARNOLD, J. A. 22 ACT FP
2170 BRIARCLIFF RD. N.E., ATLANTA 30329

ARNOLD, J. H. 2C DE1 FP
P. O. BOX 279, NEWNAN 30263

ARNOLD, M. F. 5C ACT FP
TAYLOR MEMORIAL HOSP., HAWKINSVILLE 31036

ARNOLD, MCALPIN H. 12 ACT FP
46 LAUREL DR., ELBERTON 30635

ARNOVITZ, GERSON H. 22 ACT PD
2714 CLAIRMONT RD., N.E., ATLANTA 30329

ARRAS, MILTON J. 3C ACT PATH
P.O. BOX 1518, BRUNSWICK 31520

ARRENDALE, JOE J. 1C ACT FP
8435 PRICE AVE., DOUGLASVILLE 30134

ARRUE, LUIS R. 2S ACT PD
259 ARROWHEAD BLVD, JONESBORO 30236

ARTEAGA, OLIVER 2S DE5 CALR
384 PEACHTREE ST., N.E., ATLANTA 30308

ARTIME, MANUEL E. 22 ACT AL
1275 MCCONNELL DR., DECATUR 30033

ARTRESS, GEORGE E. 17 ACT FP
2356 BELMONT CIR., S.E., SMYRNA 30080

ARWOOD, WILLIAM C., JR. 46 ACT
PELHAM 31779

ASBELL, JIMMY R. 6 ACT GR
380 HOSPITAL DR. MACON 31201

ASELMEYER, ALFRED JOHN 2S S PH
BATTEY STATE HOSP., ROME 30161

ASERON, CIRILO, JR. 54 ACT R
MEDICAL COLLEGE OF GA., AUGUSTA 30904

ASHER, HAROLD 2S ACT I
340 BOULEVARD, N. E., ATLANTA 30312

ASKEW, JAMES L. 16 ACT R
BOX 21, RIVERDALE 30274

ASKREN, EDWARD L., JR 2S ACT GPH
1293 PEACHTREE ST. NE., ATLANTA 30309

ASKREN, EDWARD L., III 2S ACT P
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

ASOKAN, SANKARAN K. 54 ACT I
MEDICAL COLLEGE OF GA. AUGUSTA 30902

ASTIN, PHIL C., JR. 1C ACT FP
702 DIXIE STREET, CARROLLTON 30117

ASTON, JAMES K. 61 ACT R
712 FORSYTH ST., AMERICUS 31709

ATHA, JOHN F. 27 ACT FP
HAGUE AVE., ROCKMART 30153

ATHA, WILLIAM J., JR. 27 DE2
RT. 5, RIVERMONT RD., ROME 30101

ATKINS, EARNEST C. 22 ACT SL
2910 N. DRUID HILLS RD., ATLANTA 30329

ATKINS, MARY T. 17 R PD
173 FOREST DR., SMYRNA 30080

ATKINSON, H. C. 6 DE5 I
724 HEMLOCK ST., MACON 31201

ATKINSON, JOHN P. 6 ACT I
724 HEMLOCK ST., MACON 31201

ATKINSON, STEWART 2S ACT GPH
705 JUNIPER ST., N.E., ATLANTA 30308

ATKINSON, THEODORE E. 6 ACT
724 HEMLOCK STREET, MACON 31201

ATWATER, JOHN S. 2S ACT GE
478 PEACHTREE ST. N.E., ATLANTA 30308

ATWATER, JOHN S., JR. 2S DE4 I
1920-26TH AVE. NW, ROCHESTER, MINN. 55901

AUSTIN, G. J., JR. 5E ACT PD
DOCTORS BLDG., VALDOSTA 31603

AUSTIN, J. L. 5S ACT CALR
610 S. 8TH ST., GRIFFIN 30223

AUSTIN, WM. F. 3C ACT
3011 KEMBLE, BRUNSWICK 31520

AVANT, EARL S. 6 ACT ANES
2923 GENERAL LEE RD., MACON 31204

AVEN, C. C. 2S DE5
ROUTE 2, MARIETTA 30060

AVERA, BERTRAM PRICE, JR. 42 S I
VA HOSPITAL, DUBLIN 31021

AVERA, JOHN B. 3C DE1
2560 TARA LA., BRUNSWICK 31520

AVERETT, JAMES E., JR. 2S ACT GR
35 COLLIER RD., N.W., ATLANTA 30309

AVERITT, THOMAS E. 44 ACT FP
P. O. BOX 408, THOMSON 30824

AVERY, ANTHONY P. 27 ACT GTC
25 BALE ST., ROME 30161

AVERY, WILLIAM G. 2S ACT GBG
275 CARPENTER DR., N.E., ATLANTA 30328

AVRET, EDWIN T. 22 ACT I
3290 MEMORIAL DR., DECATUR 30032

AYER, G. DARRELL, JR. 2S ACT PATH
BOX 12466, ATLANTA 30305

AYERS, C. L. 6C DE5 FP
TOCCOA 30577

AZAR, GORDON J. 2S ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

AZIZ, EZZAT M. 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902

B

BACKERMAN, IVAN A. 2S ACT GBG
1311 CLEVELAND AVENUE, EAST POINT 30344

BAGHERI, M.T. 13 ACT TS
14 GWINNETT DR., LAWRENCEVILLE 30245

BAILEY, A. GLENN 6B ACT SL
303 SMITH ST., LA GRANGE 30240

BAILEY, HENRY WRIGHT 54 ACT
1500 JOHNS RD., AUGUSTA 30904

BAILEY, JAMES A. 2S ACT PM
2797 CAMPBELLTON RD., S.W., ATLANTA 30311

BAILEY, JOSEPH P. 54 ACT I
TALMADGE HOSP., AUGUSTA 30902

BAILEY, M. THOMAS, JR. 2S ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BAILEY, T. E. 54 ACT PD
1111 CRUIO PARK AVE., AUGUSTA 30904

BAIRD, JOSEPH B., JR. 2S ACT P
1970 CLIFF VALLEY WAY,N.E., ATLANTA 30329

BAIRD, L. STEPHENS 2S ACT SL
1835 DELOWE DR. S.W., ATLANTA 30311

BAKER, CHARLES R. F., JR. 2S A SL
69 BUTLER ST., S. E., ATLANTA 30303

BAKER, W. R. 5C ACT SL
HAWKINSVILLE 31036

BALBONA, JOSE L. 2S ACT P
3316 PIEDMONT RD., N. E., ATLANTA 30305

BALDWIN, B. CARTER 47 ACT D
1217 PEACOCK AVE., COLUMBUS 31901

BALL, HORACE C. 22 ACT OBG
231 E. PONCE DE LEON, DECATUR 30030

BALL, WESLEY J. 11 ACT SL
1814 ABERCORN ST., SAVANNAH 31401

BALLAGAS, ANTONIO R. 2 ACT ANES
CENTRAL STATE HOSP., MILLEDGEVILLE 31061

BALLARD, MARGUERITE C. 2S ACT I
3092 ARGONNE DR., N.W., ATLANTA 30305

BAMFORD, SOPHIA 78 ACT PATH
WASHINGTON 30673

BANCKER, EVERT A., JR. 2S DE1 I
125 RIVER NORTH DR., N.W., ATLANTA 30328

BANKS, RAFE, JR. 34 ACT L
290 ENOTA DR., N. E., GAINESVILLE 30501

BANNISTER, JAMES P. 2S ACT P
478 PEACHTREE ST., N.E., ATLANTA 30308

BARFIELD, JAMES E. 57 ACT
300 ARLINGTON DR., VIDALIA 30474

BARFIELD, WILLIAM E. 54 ACT DBG
1445 HARPER ST., AUGUSTA 30902

BARFIELD, WILLIAM E., JR. 54 A CBG
MED. COLLEGE OF GA., AUGUSTA 30902

EARGERON, EUGENE P. 11 ACT GR
P.O. BOX 6156, SAVANNAH 31405

BARIA, WILLIAM F. 22 ACT I
2895 N. DRUID HILLS RD., N.E., ATL. 30329

BARKER, EDWARD C. 34 ACT FP
HALL CO HOSP., GAINESVILLE 30501

BARKER, GEORGE W., JR. 24 ACT FP
ST. MARYS CLINIC, ST. MARYS 31558

BARKSDALE, C. R., JR. 2S ACT FP
44 SMITH ST., FAIRBURN 30213

BARNES, JOHN J. 2S ACT CBG
2045 PEACHTREE RD., NE, ATLANTA 30309

BARNES, JOSEPH F. 2S ACT CBG
401 PEACHTREE ST., N.E., ATLANTA 30303

BARNES, WADDELL 6 ACT I
800 SPRING ST., MACON 31201

BARNES, WALTER P., JR. 6 ACT GR
671 HEMLOCK ST., MACON 31201

BARNETT, CRAWFORD F., JR. 2S ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

BARNETT, J. C., JR. 17 ACT NS
110 LEWIS DR., N. E., MARIETTA 30060

BARNETT, JOHN E., JR. 2S ACT P
6363 ROSWELL RD., N.E., ATLANTA 30328

BARNETT, STEPHEN T., JR. 2S ACT CBG
490 PEACHTREE ST., N.E., ATLANTA 30308

BARNWELL, WILLIAM L. 76 ACT DPH
1217 MEMORIAL DRIVE, DALTON 30720

BARR, ROBERT E. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015

BARRIOS, RONALDO C. 17 ACT P
3188 ATLANTA ST., S.E., SMYRNA 30080

BARROSO, CARLOS H. 36 ACT L
P. O. BOX 728, WARNER ROBINS 31093

BARRON, WM. E. JR. 2C ACT I
P.O. BOX 609, NEWNAN 30263

BARROW, BEN C. 1S ACT FP
946 PRINCE AVE., ATHENS 30601

BARROW, J. GORDON 2S ACT I
938 PEACHTREE ST., N.E., ATLANTA 30309

BARTHOLOMEW, PHILIP R. 2S ACT OBG
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

BARTON, DEWEY L. 5E ACT R
DOCTORS BLDG., VALDOSTA 31603

BARTON, EARL G., JR. 22 ACT PATH
2701 N. DECATUR RD., DECATUR 30030

BARTON, JAMES HOWARD 71 ACT
SOCIAL CIRCLE 30279

BARTON, WILLIAM L. 6 ACT ALR
744 FIRST ST., MACON 31201

BASHINSKI, BENJAMIN, JR. 6 ACT L
839 FIRST STREET, MACON 31201

BASKIN, HENRY J. 68 ACT I
303 SMITH ST., LAGRANGE 30240

BASKIN, J. HAGIN, JR. 29 ACT SL
490 PEACHTREE ST. N. E., ATLANTA 30308

BASS, F. DONALD 20 ACT SL
240 JACKSON ST., NEWNAN 30263

BATCHELOR, CURTIS A. 10 ACT FP
405 ALABAMA ST., BREMEN 30110

BATEMAN, J. DAN 23 ACT SL
410-12 FOURTH AVE., ALBANY 31705

BATEMAN, NEEDHAM B. 29 ACT SL
401 PEACHTREE ST., N.E., ATLANTA 30308

BATES, JACK M. 34 ACT P
500 SPRING ST., N.W., GAINESVILLE 30501

BATES, JOHN G. 53 ACT FP
201 RANDOLPH ST., CUTHBERT 31740

BATES, ROGER A. 72 ACT SL
204 PLANTATION DR., WAYCROSS 31501

BATES, W. B., JR. 72 ACT FP
WAYCROSS 31501

BATTEY, L. L. 54 ACT I
1021 15TH STREET, AUGUSTA 30901

BATTLE, LEE H., JR. 27 ACT SL
321 W 7TH STREET, ROME 30161

BATTS, A. S. 50 ACT
HAWKINSVILLE 31036

BAUGH, JAMES E. 2 ACT FP
811 N. COBB, MILLEDGEVILLE 31061

BAUGH, WILBUR E. 2 ACT R
P. O. BOX 926, MILLEDGEVILLE 31062

BAUTISTA, GRACE C. 62 ACT PD
P.O. BOX 406 FRASER DR., HINESVILLE 31313

BAUTISTA, VICTOR C. 62 ACT ANES
LIBERTY MEMORIAL HOSP., HINESVILLE 31313

BAYNE, LOUI G. 29 ACT OR
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BAZEMORE, J. MALCOLM 54 ACT D
1467 HARPER ST., AUGUSTA 30902

BAZEMORE, W. L. 6 DE1 L
195 BEVERLY PLACE, MACON 31204

BEACH, BESSIE MAE 47 S PD
17 BALENTINE DR., GREENVILLE, S. C. 29605

BEACH, WILLIAM R., III 29 ACT PATH
731 W. PEACHTREE ST., N.E., ATLANTA 30308

BEALL, AVERY P. 56 ACT FP
P. O. BOX 129, ADEL 31620

BEALL, JAMES H. 15 ACT P
700 OGLETHORPE AVE., ATHENS 30601

BEARD, CARL L. 36 ACT OBG
105 BRIARCLIFF, WARNER ROBINS 31093

BEARD, DONALD E. 29 DE1 L
400 LOG CABIN DR., SMYRNA 30080

BEASLEY, CARROLL 17 ACT
50 PLAZA WAY, MARIETTA 30060

BEASLEY, ERNEST W., JR. 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

BECERRA, HERNAN 29 ACT FP
2741 BAYARD ST., EAST PT. 30344

BECHTEL, H. BERNARD 56 ACT D
2101 N. PATTERSON ST., VALDOSTA 31603

BECTON, JAMES L. 54 ACT OR
1521 ANTHONY RD., AUGUSTA 30904

BEDINGFIELD, JAMES ANDREW 1 ACT
BAXLEY 31513

BEDINGFIELD, W. H. 57 ACT FP
P. O. BOX 629, VIDALIA 30474

BEDINGFIELD, W. O. 11 DE5
1020 DRAYTON ST., SAVANNAH 31401

BEDINGFIELD, W. R., JR. 54 ACT I
N. AUGUSTA, SO. CAROLINA 29841

BEECHAM, PAUL E. 17 ACT P
11457 HACKETT RD., ROSWELL 30075

BEESON, CHARLES H., II 11 ACT C
803 E. 70TH ST., SUITE 103, SAVANNAH 31405

BELCHER, WILLIAM T., JR. 22 ACT OPH
2754 N. DECATUR RD., DECATUR 30033

BELK, BEVERLY 54 ACT PD
1723 1/2 KISSINGBOWER RD., AUGUSTA 30904

BELL, EUGENE D. 18 ACT
DOUGLAS 31533

BELL, FRED M., JR. 29 ACT SL
478 PEACHTREE ST., N. E., ATLANTA 30308

BELL, HUGH V., JR. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344

BELL, J. A., JR. 42 ACT FP
DUBLIN MEDICAL ARTS CENTER, DUBLIN 31021

BELL, J. E. 54 ACT PD
1411 GWINNETT ST., AUGUSTA 30902

BELL, RUDOLPH 65 DE5 L
P.O. BOX 1675, THOMASVILLE 31792

BELL, SIDNEY A. 27 ACT GR
HARBIN CLINIC, ROME 30161

BELLVILLE, CHAS. GEORGE 21 ACT SL
BAINBRIDGE 31717

BENNETT, J. W. 54 ACT PD
1467 HARPER ST., AUGUSTA 30902

BENNETT, ROBERT L. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

BENNETT, VAN B. 56 ACT I
RT. 1, BOX 2, VALDOSTA 31601

BENNETT, V. H. 45 DE5 FP
801 RIVERHILL DR., ATHENS 30601

BENNETT, W. FRED, JR. 29 ACT I
3250 HOWELL MILL RD., N.E., ATL 30327

BENNETT, WM. H. 29 DE3 L
829 W. WESLEY RD., N.W., ATL. 30327

BENSON, EARL B. 17 ACT ANES
KENNESTONE HOSPITAL, MARIETTA 30061

BENSON, RICHARD L. 18 ACT R
BOX 1077, DOUGLAS 31533

BENSON, W. H., JR. 17 ACT I
ROUTE 4, MARIETTA 30060

BENTLEY, ALONZO J. 65 ACT CALR
918 S. BROAD ST., THOMASVILLE 31792

BERENS, SANFORD V. 11 ACT R
5223 PAULSEN ST., SAVANNAH 31405

BERENSON, MORTON P. 47 ACT I
2748 SUE MACK DR., COLUMBUS 31906

BERG, EDWARD W. 54 ACT GR
MEDICAL COLLEGE OF GA., AUGUSTA 30902

BERG, JOSEPH L. 23 ACT OPH
P. O. BOX 483, ALBANY 31702

BERGER, ISRAEL REUBEN 15 ACT R
1010 PRINCE AVENUE, ATHENS 30601

BERGER, LOUIS 29 ACT OPH
950 W. PEACHTREE ST. N. W., ATLANTA 30309

BERGER, MERTON B. 29 ACT P
5600 ROSWELL RD., N.E., ATLANTA 30042

BERGHERM, BRUCE A. 29 ACT ANES
1968 PEACHTREE RD., N. W., ATLANTA 30309

BERLIN, MELVIN 11 ACT
1 MIDTOWN MEDICAL CENTER, SAVANNAH 31401

BERMAN, DAVE 47 ACT D
1315 4TH AVE., COLUMBUS 31901

BERMAN, JEROME D. 29 ACT PD
6500 VERNON WOODS RD., N.E., ATLANTA 30328

BERN, GERHARD O. 29 S I
275-5TH ST., NW, ATLANTA 30332

BERNSTEIN, JEFFREY A. 29 ACT OBG
3312 PIEDMONT RD., N.E., ATLANTA 30305

BERRY, ARTHUR N. 47 R OBG
1730 SE. 40 ST., COLUMBUS 31904

BERRY, C. MARKHAM 29 DE2 FP
4665 MYSTIC DR., N.E., ATLANTA 30342

BERRY, JOSEPH N. 29 ACT I
6500 VERNON WOODS DR., N. E., ATL. 30328

BERRY, ROBERT L. 10 ACT FP
VILLA RICA 30180

BETHEA, JAMES S., III 17 ACT GR
1664 W. WESLEY RD., ATLANTA 30327

BICKERS, DONALD 29 ACT NS
3250 HOWELL MILL RD.,NE, ATLANTA 30327

BICKERSTAFF, HUGH J. 47 DE5 OBG
MEDICAL ARTS BLDG., COLUMBUS 31901

BICKERSTAFF, JAMES W., JR 72 OCT GR
1921 ALICE ST., WAYCROSS 31501

BIENERT, HENRY J. 29 ACT GR
1311 CLEVELAND AVE., EAST POINT 30344

BIGGERS, WILLIAM H. 29 ACT P
1365 CLIFTON RD., N. E., ATLANTA 30322

BILLINGHURST, GEORGE A. 54 OE1 FP
VA HOSPITAL, COLUMBIA, S. C. 29201

BILLINGS, J. E. 31 OE1 FP
CALHOUN 30701

BILLIPS, WILLIAM C. 22 ACT OPH
3576 CHAMBLEE TUCKER RD., ATLANTA 30341

BILSTEN, GEORGE G. B. 29 ACT N
35 COLLIER RD., N.W., ATLANTA 30309

BIRCH, HERBERT W. 29 ACT OBG
1365 CLIFTON RD., N. E., ATLANTA 30322

BIRDSONG, WM. R. 6 ACT PD
531 NORTH AVE., MACON 31201

BISHOP, JOSEPH A. 31 ACT FP
103 S. RIVER ST., CALHOUN 30701

BISHOP, LINTON H., JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308

BITTLE, CHARLES R. 54 ACT ANES
812 13TH ST., AUGUSTA 30902

BIVENS, EDWARD S. 29 ACT R
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BIVINGS, F. LEE 29 DE5 PD
3110 HABERSHAM RD., NW, ATLANTA 30305

BIVINS, BLAKE S. 50 ACT FP
BEECH ST., COCHRAN 31014

BLACK, CLYDE E. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344

BLACK, GRADY E. 59 ACT PD
567 S. 9TH ST., GRIFFIN 30223

BLACK, PAUL W. 22 ACT PL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BLACK, WILEY S. 34 ACT SL
1114 VINE ST., N.E., GAINESVILLE 30501

BLACKBURN, J. D. 69 DE5 GR
211 THURSTON AVE., THOMASTON 30286

BLACKMAN, WILLIAM M. 76 ACT OPH
1217 MEMORIAL DR., DALTON 30720

BLACKSHEAR, JOSEPH R. 23 ACT EM
P.O. BOX 1828, ALBANY 31702

BLACKSHEAR, STUART G. 34 ACT SL
1114 VINE ST., N. E., GAINESVILLE 30501

BLACKSTON, RONALD D. 22 ACT PD
1365 CLIFTON RD., N.E., ATLANTA 30322

BLAINE, B. C. 29 ACT I
2034 MAIN STREET, N. W., ATLANTA 30318

BLAIR, H. DUANE 22 ACT SL
755 COLUMBIA DR., DECATUR 30030

BLALOCK, H. SHERMAN 54 ACT GR
1515 POPE AVE., AUGUSTA 30904

BLALOCK, JACK H., JR. 47 ACT I
MEDICAL ARTS BLDG., COLUMBUS 31901

BLALOCK, JOHN C. 29 DE5 SL
734 W. WESLEY RD., N. W., ATLANTA 30327

BLALOCK, TULLY T. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

BLALOCK, TULLY T., JR. 29 DE2 I
EMORY UNIV. HOSP., ATLANTA 30322

BLANC, JAMES S. 17 ACT SL
1678 MULKEY RD., AUSTELL 30001

BLANCHARD, HUBERT H. 59 ACT P
720 HOLMES ST., BARNESVILLE 30204

BLANCHARD, MERCER 47 DE5 PD
NO CURRENT ADDRESS

BLANCHARD, MERCER C. 47 ACT PD
713 20TH ST., COLUMBUS 31904

BLANCHARD, THOMAS W. 54 ACT L
1502 ANTHONY RD., AUGUSTA 30904

BLANCHARD, WILLIAM 27 ACT SL
CEDARTOWN 30125

BLANC, JAMES W., JR. 2S ACT ANES
1364 CLIFTON RD., N.E., ATLANTA 30322

BLANK, SAMUEL 2S S
1670 CLAIRMONT RD, NE, DECATUR 30033

BLASINGAME, JOHN T., JR. 2S ACT SL
75 PIEDMONT AVE., N. E. ATLANTA 30303

BLEICH, ALLAN C. 2S ACT I
5675 PTREE-DNWCY RD.,N.E., ATL. 30342

BLEICH, J. K. 2S ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

BLISSIT, JOSEPH A. 5S ACT I
169 DECATUR ROAD, MCDONOUGH 30253

BLITCH, PIERCE G., JR. 54 ACT I
1505 WINTER ST., AUGUSTA 30904

BLIVEN, FLOYD E., JR. 54 ACT OR
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902

BLOCK, DONALD L. 2S ACT CBG
100 COLONY SQ., SUITE 1601, ATLANTA 30309

BLOODWORTH, AUGUSTUS F. 34 ACT I
109B S. ENOTA, N. E., GAINESVILLE 30501

BLOODWORTH, H. T. 6 ACT ANES
781 SPRING ST., MACON 31201

BLOODWORTH, RONALD C. 17 ACT P
3188 ATLANTA ST., S.E., SMYRNA 30080

BLOOM, WALTER L. 17 ACT
225 NORTH AVE., N. W., ATLANTA 30313

BLOOM, WILLIAM F. 6 ACT R
777 HEMLOCK ST., MACON 31204

BLUE, JACOB S. 36 S IND
CIVILIAN CLINIC, WARNER ROBINS AFB 31094

BLUMBERG, MAX M. 2S ACT I
33 PONCE DE LEON AVE., N.E., ATLANTA 30308

BLUMBERG, RICHARD W. 2S ACT PD
69 BUTLER ST. S. E., ATLANTA 30303

BLUMENTHAL, IRVIN 2S ACT SL
384 PEACHTREE ST. N. E., ATLANTA 30308

BLUMENTHAL, JEROME B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060

BOATWRIGHT, MARTHA H. 2S ACT P
1970 CLIFF VALLEY WAY NE., ATLANTA 30329

BOBO, W. EARL 22 ACT SL
365 WINN WAY, DECATUR 30030

BODDIE, A. M. 2 ACT FP
240 N. WAYNE ST., MILLEDGEVILLE 31061

BOODY, A. EVAN 14 ACT
WOODSTOCK 30188

BODZINER, L. S. 11 ACT CBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405

BOGER, RICHARD E. 2S ACT PD
5675 PTREE-DNWCY RD., STE. 502, AT 30342

BOGGESS, NEIL D., JR. 76 ACT
1012 BURLEYSON DR., DALTON 30720

BOHANAN, G. WAYNE 36 ACT R
HOUSTON CO. HOSP., WARNER ROBINS 31093

BOHLER, CHARLES EMORY 8 ACT FP
BOX B, BROOKLET 30415

BOHLER, CLORINDA S. 54 ACT EM
2279 WRIGHTSBORO RD., AUGUSTA 30904

BOHORFOUSH, J. G. 2 ACT I
MILLEDGEVILLE 31061

BOLLET, ALFRED J. 54 ACT I
MED. CTR., SUNNY DOWNSTATE, BROOKLYN 11203

BOLTON, RICHARD S. 23 ACT PH
1109 N. JACKSON ST., ALBANY 31705

BONAU, ROGELIO 48 ACT SL
5303 ADAMS ST., COVINGTON 30209

BONOURANT, WILLIAM 2S ACT GR
478 PEACHTREE ST., NE, ATLANTA 30308

BONNER, JOHN T. 2S ACT ANES
69 BUTLER ST., S. E., ATLANTA 30303

BONNER, WILLIAM F. 15 ACT PD
740 PRINCE AVE., ATHENS 30601

BOOTH, ARTHUR S. 2S ACT SL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BOOTLE, WM. A., JR. 6 ACT R
2056 VINEVILLE AVE., MACON 31201

BOOZER, ALBERT MARION 76 ACT FP
DALTON MEM. ARTS BLDG., DALTON 30720

BORDERS, JUEL PATE 2S ACT CBG
375 AUBURN AVE., S.E., ATL. 30312

BORDON, JOSE ANTONIO 2S ACT ANES
159 FOREST AVE., N. E., ATLANTA 30303

BOSS, JAMES L. 10 ACT FP
VILLA RICA 30180

BOSTWICK, JOHN, III 2S ACT PL
25 PRESCOTT ST., NE, ATLANTA 30308

BOSWELL, JOHN R. 2S ACT ANES
6237 BLACKWATER TRAIL N.W., ATLANTA 30328

BOSWELL, T. C. 14 ACT FP
TATE 30177

BOSWELL, W. C. 65 DE5 PD
P.O. BOX 1378, THOMASVILLE 31792

BOSWORTH, E. L. 27 ACT I
HARBIN CLINIC, ROME 30161

BOTNICK, ROBERT S. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904

BOTTOMS, WM. R. 13 ACT FP
601 US HWY 19N, CUMMING 30130

BOTTOMY, JOHN R. 2S ACT CBG
2794 WOODLAKE PARK DR., N. E., ATL. 30329

BOUSQUET, FRANKLYN P., JR 11 ACT CPH
P.O. BOX 13919, SAVANNAH 31402

BOWCOCK, JAMES Z. 22 ACT P
755 COLUMBIA CR., DECATUR 30030

BOWDEN, RALPH O. 11 ACT
22 W. TAYLOR ST., SAVANNAH 31401

BOWDEN, TALMADGE A., JR. 54 ACT SL
MED. COLLEGE OF GA., AUGUSTA 30902

BOWEN, EDWARD G. 2S ACT CBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BOWEN, J. B. 54 ACT SL
842 GREENE ST., AUGUSTA 30902

BOWEN, JOHN L. 54 DE2 PD
P. O. BOX 1637, ORANGEBURG, S. C. 29115

BOWEN, ROBERT W. 2S ACT OBG
217 ARROWHEAD BLVD., JONESBORO 30236

BOWEN, WILLIAM L., JR. 15 ACT CBG
1010 PRINCE AVE., ATHENS 30601

BOWER, THOMAS L. R. 17 ACT ANES
705 JUNIPER ST., NE, ATLANTA 30308

BOWERS, ROBERT E. 76 OE2 FP
721 GLENWOOD CR., CHATTANOOGA, TENN. 37404

BOWLES, F. NORMAN, JR. 17 ACT PATH
3950 AUSTELL RD., AUSTELL 30001

BOWLES, LESTER L. 54 ACT P
P. O. BOX 4687, MARTINEZ 30907

BOWMAN, M. B. 23 ACT SL
1104 N. MONROE ST., ALBANY 31705

BOWYER, FRANK P. 66 ACT PD
418 N. PARK AVE., TIFTON 31794

BOYD, AUGUSTUS B. 15 ACT ANES
P. O. BOX 1732, ATHENS 30601

BOYD, CLAUD A., JR. 54 ACT D
1509 ANTHONY RD., AUGUSTA 30904

BOYD, DONALD L. 23 ACT CR
1105 PALMYRA RD., ALBANY 31701

BOYD, HARTWELL 30 DE1 CBG
P. O. BOX 1738, ST. SIMONS ISLAND 31522

BOYD, RONALD A. 2 ACT FP
511 N. COBB, MILLEDGEVILLE 31061

BOYD, WM. S. 54 ACT OBG
1503 WINTER ST., AUGUSTA 30904

BOYETT, JAMES E. 2S ACT TS
P. O. BOX 429, EAST POINT 30344

BOYETTE, DAVID M. 23 ACT LIC
804 FOURTEENTH AVE., ALBANY 31705

BOYTER, HENRY H. 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901

BRACKETT, J. CORDON 2S ACT ALR
340 BOULEVARD, N.E., ATLANTA 30312

BRACKETT, MORRIS E. 2S A
47 TRINITY AVENUE, S.W., ATLANTA 30334

BRACKNEY, EDWIN L. 54 ACT SL
BOX 521, V A HOSP., TUSKEGEE, ALA 36083

BRADBURY, ROBERT G. 11 ACT R
311 E. HALL ST., SAVANNAH 31401

BRADFORD, F. B. 4 DE5 FP
103 VALLEY DR., CARTERSVILLE 30120

BRADLEY, CHARLES K. 34 ACT CPH
112B VINE ST., GAINESVILLE 30501

BRADLEY, PAUL L. 76 ACT SL
P.O. 1969, DALTON 30720

BRADLEY, R. H. 76 DE5
CHATSWORTH 30705

BRALY, SAMUEL U. 17 ACT FP
CALLAS 30132

BRAMBLETT, A. W., JR. 6 ACT FP
99 COUNTRY CLUB CR., FORSYTH 31029

BRAMBLETT, RUPERT H. 13 ACT FP
326 DAHLONEGA RD., CUMMING 30130

BRANAN, WM. J., JR. 22 ACT PD
1989 N. WILLIAMSBURG DR., DECATUR 30033

BRANCH, DAVID L., JR. 56 ACT OR
DOCTORS BLDG., VALDOSTA 31603

BRANCON, R. V. 5S DE1 FP
WESTBURY MED CARE HOME, JENKINSBURG 30234

BRANDT, HENRY A. 11 ACT PA
220 EAST HALL STREET, SAVANNAH 31401

BRANNEN, EDMUND A. 6 ACT OBG
675 NEW STREET, MACON 31201

BRANNEN, J. H. 56 ACT L
401 WOODROW WILSON DR., VALDOSTA 31603

BRANNEN, JAMES O. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033

BRANNON, EMMETT S. 27 ACT I
MCCALL HOSPITAL, ROME 30162

BRANNON, LAWRENCE T. 2S ACT P
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BRANSOME, EDWIN D., JR. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

BRANTLEY, J. C. 42 DE5 FP
WRIGHTSVILLE 31096

BRANTLEY, MARVIN A. 2S ACT P
1365 CLIFTON RD., N.E., ATLANTA 30322

BRANTLY, EDMUND B. 2S ACT R
20 LINDEN AVE., N.E., ATLANTA 30308

BRANYON, DONALD L., JR. 15 ACT CBG
1010 PRINCE AVE., ATHENS 30601

BRASWELL, L. RENDER 2S R FP
143 W. PACE FERRY RD., N.W., ATLANTA 30305

BRAWNER, D. L. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403

BRAWNER, JAMES N., III 2S ACT I
35 COLLIER RD., N.W., ATLANTA 30309

BRECKENRIDGE, F. E., JR. 21 ACT FP
HOSPITAL CIRCLE, DONALSONVILLE 31745

BREGMAN, LARRY 2S ACT PD
4536 CHAMBLEE-DUNWOODY RD., ATLANTA 30341

BREIBART, SIDNEY 22 ACT PD
11 LAVISTA PER. OFC. PK., TUCKER 30084

BRENNAN, CARL H. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405

BREWER, JOHN M., JR. 2S ACT D
384 PEACHTREE STREET, N.E. ATLANTA 30308

BREWER, PHILIP L. 47 ACT IS
MEDICAL ARTS BLDG., COLUMBUS 31901

BREWER, SPENCER S., JR. 2S ACT I
1938 PEACHTREE RD., NW, ATLANTA 30309

BREWTON, SAMUEL A. JR. 6S ACT L
612 W. GORDON RD., THOMASTON 30286

BRIANT, THOMAS P. 6 ACT ANES
4360 OLD CLUB RD., MACON 31204

BRICE, ANTON, JR. 22 ACT I
542 CHURCH ST., DECATUR 30030

BRICE, BOYCE S. 27 ACT SL
THE HARBIN CLINIC, ROME 30161

BRIDGER, CLARENCE E. 23 ACT PATH
P.O. BOX 1828, ALBANY 31702

BRIDGES, HENRY B. 54 ACT OR
1413 GWINNETT ST., AUGUSTA 30902

BRIDGES, MERCER T. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904

BRIDGES, WILLIAM H. 23 ACT R
P. O. BOX 1828, ALBANY 31702

BRIDGES, W. L., JR. 66 ACT PD
714 E. 18TH, TIFTON 31794

BRIGGS, WM. JESSE, III 5C ACT FP
MILAN 31060

BRIGHTWELL, LARRY E. 47 ACT SL
105 DOCTORS BLDG., COLUMBUS 31901

BRILL, HARRY H., JR. 47 ACT I
1905 SEVENTH AVE., COLUMBUS 31901

BRINKLEY, AVERY B. 6 ACT R
312 CANDLER DR., MACON 31204

BRINSFIELD, DOROTHY 29 ACT PD
2236 SPRING CREEK RD., DECATUR 30033

BRINSON, JOHN B., JR. 65 ACT FP
808 GORDON AVE., THOMASVILLE 31792

BRISCO, C. D. 71 DE5 I
MONROE 30655

BRITT, C. S. 3C DE5 FP
P.O. BOX 1078, ST. SIMONS ISLAND 31522

BRIZEL, HERBERT E. 54 ACT R
1467 HARPER ST., AUGUSTA 30902

BROCATO, SIMONE 47 ACT C
PHYSICIANS BLDG., COLUMBUS 31901

BROCK, ROY CRAWFORD 27 ACT SL
14 PROFESSIONAL COURT, ROME 30161

BRODERICK, JOHN R. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

BRONSTEIN, EDWIN S. 54 ACT CBG
MED. COLLEGE OF GA., AUGUSTA 30902

BROOKS, BETTY ANN 22 ACT CBG
365 WINN WAY, DECATUR 30030

BROOKS, CHARLES P. 48 ACT FP
NO CURRENT ADDRESS

BROOKS, COURTNEY C. 22 ACT FP
2223 CANDLER ROAD, DECATUR 30032

BROOKS, W. SCOTT, JR. 29 ACT I
1365 CLIFTON RD, NE, ATLANTA 30322

BROOME, HARRY L. 29 ACT OR
960 JOHNSON FERRY RD., N.E., ATLANTA 30328

BROWN, ALAN P. 11 ACT EH
P. O. BOX 13312, SAVANNAH 31406

BROWN, ALGIE C. 29 ACT P
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BROWN, ALLEN N. 54 ACT FP
1439 CRUIDPK. AVE., F., AUGUSTA 30904

BROWN, AUDREY K. 54 ACT PD
450 CLARKSON AVE., BROOKLYN, N.Y. 11203

BROWN, BOBBY C. 29 ACT PATH
1364 CLIFTON RD., N.E., ATLANTA 30322

BROWN, CHARLES E. 29 ACT I
21 EIGHTH ST. N. E., ATLANTA 30309

BROWN, CHARLES T. 11 DE5 PH
BOX 7, GUYTON 31312

BROWN, CHARLES W. 29 ACT CR
478 PEACHTREE ST., N.E., ATLANTA 30308

BROWN, COLEMAN M. 29 ACT P
1938 PTREE RD. NW., ATLANTA 30309

BROWN, DEMPSEY S. 6 ACT SL
740 HEMLOCK ST., MACON 31201

BROWN, DWIGHT J., JR. 3C ACT OBG
3020 SHRINE RC., BRUNSWICK 31520

BROWN, EDWARD B. 72 ACT CBG
P. O. BOX 177, WAYCROSS 31501

BROWN, ELBERT H. 36 ACT FP
212 HOSPITAL DR., WARNER ROBINS 31093

BROWN, F. BERT 11 DE1 GR
17 E. 52ND ST., SAVANNAH 31405

BROWN, GEORGE W. 59 ACT R
686 S. 8TH STREET, GRIFFIN 30223

BROWN, GROVER J. 4 ACT FP
P. O. BOX 338, LINDALE 30147

BROWN, H. EUGENE 29 DE1 I
622 PARK LN., DECATUR 30033

BROWN, HOWARD S. 29 ACT TS
6500 VERNON WOODS DR., N.E., ATL. 30328

BROWN, JAMES A. 54 ACT GPH
1445 HARPER ST., AUGUSTA 30902

BROWN, JIMMY S. 29 ACT PD
3162 PIEDMONT RD., N.E., ATLANTA 30305

BROWN, JOSEPH CHRISTOPHER 48 ACT FP
CONYERS 30207

BROWN, JOSEPH E. 3C ACT CR
3104 SHRINE RC., BRUNSWICK 31520

BROWN, LEONARD 17 ACT D
1416 CHEROKEE STREET, MARIETTA 30062

BROWN, LESTER A. 29 ACT ALR
490 PEACHTREE ST. N. E., ATLANTA 30308

BROWN, LUTHER E. 6 ACT GPH
800 FIRST ST., MACON 31201

BROWN, MARK 54 ACT R
TALMADGE MEMORIAL HOSP., AUGUSTA 30902

BROWN, NELSON H. 29 ACT I
478 PEACHTREE ST., N. E., ATLANTA 30308

BROWN, P.F., JR. 34 ACT SL
1114 VINE ST., N.E., GAINESVILLE 30501

BROWN, R. G. 29 DE1 FP
SWAINSBORO 30401

BROWN, RICHARD M. 17 ACT GPH
653 CHEROKEE ST., MARIETTA 30060

BROWN, ROBERT H. 29 ACT ALR
3280 HOWELL MILL RD., N.W., ATLANTA 30327

BROWN, ROBERT L. 29 ACT SL
R. WINSHIP CL, EMORY HOSP., ATLANTA 30322

BROWN, ROLAND A. 6 R CBG
306 ORANGE ST., MACON 31201

BROWN, S. ROSS 29 DE1 ANES
NO CURRENT ADDRESS

BROWN, SOLOMON K. 54 ACT R
1467 HARPER STREET, AUGUSTA 30904

BROWN, STEPHEN W. 54 ACT R
1467 HARPER ST., AUGUSTA 30904

BROWN, STEWART D., JR. 28 ACT FP
200 FRANKLIN SPRINGS ST., ROYSTON 30662

BROWN, THOMAS D., JR. 34 ACT GTC
304 ENOTA CR., GAINESVILLE 30501

BROWN, WALTER J., JR. 15 ACT I
UNIV HEALTH SERVICE, ATHENS 30602

BROWN, W. MORRIS, JR. 6 ACT SL
655 FIRST ST., MACON 31201

BROWNE, RODNEY M. 6 ACT OBG
380 HOSP., DR., MACON 31201

BROWNE, THOMAS MORGAN 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345

BROWNSBERGER, JOHN F. 56 DE5 SL
LAKELAND 31635

BRUCE, DOUGLAS A. 3C ACT PD
520 OCEAN BLVD., ST. SIMONS IS. 31522

BRUCKNER, HOWARD L. 54 ACT GPH
905 15TH ST., AUGUSTA 30902

BRUNER, BARBARA 29 A PD
69 BUTLER ST., S. E., ATLANTA 30303

BRUNT, GWYNNE T., JR. 29 ACT R
3312 PIEDMONT RD., N.E., ATLANTA 30305

BRUNS, WM. L., JR. 54 ACT OBG
1430 HARPER ST., AUGUSTA 30902

BRYANS, C. I., JR. 54 ACT OBG
TALMADGE HOSP., AUGUSTA 30902

BRYANT, C. H. 15 DE5 FP
COMER 30629

BRYANT, JAMES M., JR. 2C ACT
NEWNAN 30263

BRYANT, MILTON F., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

BRYANT, V. L. 39 DE5
MADLEY 30477

BUCHANAN, L. C. 22 ACT SL
374 W. PONCE DE LEON AVE., DECATUR 30030

BUCKHAULTS, W. W. 11 ACT GPH
905 ABERCORN STREET, SAVANNAH 31401

BUCKNER, LESLIE MARVIN 23 ACT G
ROUTE 2, BOX 446, LEESBURG, GA. 31763

BUCKNER, MICHAEL S. 23 ACT PATH
ROUTE ONE, HEADLAND, ALA. 36345

BUELVAS, RAUL S. 11 ACT SL
11706 MERCY BLVD., SAVANNAH 31406

BUNNEN, ROBERT L. 29 A SL
3312 PIEDMONT RD., NE ATLANTA 30305

BUNYASARANAND, PRICHA 59 ACT D
610 S. 8TH ST., GRIFFIN 30223

BURDISON, WM. R. 54 S
V.A. HOSPITAL, AUGUSTA 30904

BURGAMY, CLYDE A. 54 ACT CBG
DRS. HOSPITAL PLAZA AUGUSTA 30904

BURGE, DAN 29 ACT I
315 BOULEVARD N.E., ATLANTA 30312

BURGSTINER, CARSON B. 11 ACT CBG
118 E. 35TH ST., SAVANNAH 31401

BURK, BILLY D. 47 A CBG
MARTIN ARMY HOSP., FT. BENNING 31905

BURLEIGH, BRUCE D. 17 ACT FP
115 MOORES AVENUE, MARIETTA 30062

BURNETT, STACY W. 22 ACT PD
2100 PARKLAKE DR., N.E., ATLANTA 30345

BURNHAM, JAMES W., JR. 6 ACT FP
1923 JEFFERSONVILLE RD., MACON 31201

BURNS, D. L. 56 DE5 FP
P.O. BOX 189, LAKE PARK 31636

BURNS, JAMES B. 17 ACT R
737 CHURCH ST., MARIETTA 30061

BURNS, JAMES R., JR. 34 ACT FP
700 S. ENOTA CR., N. E., GAINESVILLE 30501

BURNS, JOHN KNOX, III 34 ACT CBG
1100 VINE STREET, GAINESVILLE 30501

BURNS, MATTHEW L. 2C ACT SL
15 CAVENDER ST., NEWNAN 30263

BURNS, R. A. 7 ACT FP
BLUE RIDGE 30513

BURNS, WILLIAM B., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

BURR, MAX E. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31902

BURRELL, ZEB, JR. 15 ACT I
ATHENS GENERAL HOSP., ATHENS 30601

BURROUGHS, GERALD W. 54 ACT P
EUGENE TALMADGE MEM. HOSP., AUGUSTA 30902

BURSON, E. NAPIER, JR. 29 ACT I
340 BOULEVARD, N.E., ATLANTA 30312

BURTON, CHARLES G. 6 ACT SL
740 HEMLOCK ST., MACON 31201

BURTON, HERBERT W. 29 ACT I
384 PEACHTREE ST., N. E., ATLANTA 30308

BUSBEE, PERRY G. 26 ACT FP
CORDELE 31015

BUSEY, T. J. 16 DE5 FP
FAYETTEVILLE 30214

BUSEY, THOMAS J., JR. 29 ACT L
2748-B FELTON DR., EAST POINT 30344

BUSH, CHARLES K. 29 ACT P
47 TRINITY AVE., S.W., ATLANTA 30334

BUSH, JAMES L. 42 S CALR
VETERANS HOSPITAL, DUBLIN 31021

BUSH, JOHN 47 DE5 FP
P. O. BOX 141, COLUMBUS 31902

BUSH, LEON H. 23 ACT I
1009 N. MONROE, ALBANY 31701

BUSH, O. B. 29 DE5 FP
57 RUMSON WAY, N.E., ATLANTA 30305

BUSSEY, J. G. 17 ACT SL
AUSTELL 30001

BUSSEY, JOSEPH G., JR. 17 ACT SL
5990 LOVE ST., AUSTELL 30001

BUTLER, CHARLES W., JR. 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BUTLER, CLARENCE 47 ACT I
P. O. BOX 4195, COLUMBUS 31904

BUTLER, RICHARD H. 29 S
P. O. BOX 20636, ATLANTA 30320

BUTLER, WALTER H. 29 ACT ANES
1110 VERNON SPGS. CT., N.W., ATLANTA 30327

BUTTERWORTH, HENRY H. 22 ACT I
603 CHURCH STREET, DECATUR 30030

BUTTS, JAMES A. 34 ACT I
1732 VALLEY RD., N.E., GAINESVILLE 30501

BUVINGER, R. S. 42 S
VA CENTER, DUBLIN 31021

BUXTON, HUBERT, JR. 6 ACT ANES
4928 GUERRY DR., MACON 31204

BYARS, STEVENS 6E ACT PH
406 COUNTRY CLUB RD., LAGRANGE 30240

BYNE, J. M., JR. 9 ACT I
LIBERTY ST., WAYNESBORO 30830

BYRAM, JAMES F. 29 OE5 OBG
3080 RIDGEWOOD RD., N. W., ATLANTA 30327

BYRD, M. DANIEL 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

BYRNES, WILLIAM F. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344

C

CABANISS, C. DANIEL 47 ACT I
P.O. BOX 951, COLUMBUS 31902

CABANISS, W. HARVEY, JR. 15 ACT O
1010 PRINCE AVENUE, ATHENS 30601

CABRERA-CICERO, ORLANDO 42 S SL
VA CENTER, DUBLIN 31021

CABRERA-MENDEZ, FABIO 29 OE2 P
80 BUTLER ST., S.E., ATLANTA 30303

CACCHIOLI, LOUIS G. 2E ACT FP
HARTWELL 30643

CAIN, ROBERT T. 65 ACT FP
P.O. BOX 231, QUITMAN 31643

CALDWELL, JOSEPH L., JR. 54 ACT SL
808 13TH ST., AUGUSTA 30901

CALDWELL, KENDALL W. 15 ACT R
797 COBB ST., ATHENS 30601

CALHOUN, F. P., JR. 29 ACT OPH
1365 CLIFTON RD., N. E., ATLANTA 30322

CALHOUN, W. C. 72 ACT CB
P. O. BOX 1091, WAYCROSS 31501

CALLAWAY, GEORGE M., JR. 29 S I
1670 CLAIRMONT RD., N. E., ATLANTA 30329

CALVERT, JON C. 54 ACT FP
MED. COLLEGE OF GA., AUGUSTA 30902

CALVERT, WILSON C. 45 ACT I
WARM SPRINGS FOUNDATION, WARM SPRINGS 31830

CAMBLOR, GONZALO 17 ACT PATH
COBB GENERAL HOSP., AUSTELL 30001

CAMPA, JOSE C. 56 ACT GR
1807 JERRY JOHNS DR., VALDOSTA 31601

CAMPBELL, CLARENCE G., JR 42 ACT R
LAURENS CO. HOSP., DUBLIN 31021

CAMPBELL, HAROLD EUGENE 12 ACT FP
46 LAUREL AVENUE, ELBERTON 30635

CAMPBELL, JOHN C. 72 ACT L
408 ZACHRY ST., WAYCROSS 31501

CAMPBELL, LEONARD H. 6 ACT PATH
548 FIRST ST., MACON 31201

CAMPBELL, RICHARD P. 27 ACT FP
CEDARTOWN 30125

CAMPBELL, WALLACE G. 29 ACT PATH
EMORY UN. SCH. OF MEDICINE, ATLANTA 30322

CANNON, CLIFTON L., JR. 11 ACT NS
22 MEDICAL ARTS CTR., SAVANNAH 31405

CAPLAN, DANIEL B. 29 ACT PD
69 BUTLER ST., S. E., ATLANTA 30303

CAPLAN, GERALD E. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405

CAPLAN, J. LOUIS 29 RET OTC
NO CURRENT ADDRESS

CARAS, THOMAS S. 17 ACT I
641 CHURCH ST., MARIETTA 30062

CARBAUGH, ROBERT G. 72 ACT ANES
1921 ALICE ST., WAYCROSS 31501

CARDEN, BRADLEY L. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

CARDOSO, DAVID 2 ACT OBG
P.O. BOX 489, MILLEDGEVILLE 31062

CAREY, FLOYD THOMAS 76 DE2 FP
UNIV. OF MISS., JACKSON, MISS. 39200

CARGILE, KENNETH R. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

CARICO, JAMES M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

CARLINER, NATHAN H. 29 ACT I
1285 PEACHTREE ST., N.E., ATLANTA 30305

CARLISLE, O. B. 29 ACT OPH
3158 MAPLE DR., N. E., ATLANTA 30305

CARLOCK, KELLER S. 29 ACT PD
3162 PIEDMONT RD., N. E., ATLANTA 30305

CARLTON, FRANK E. 11 ACT U
P.O. BOX 3458, SAVANNAH 31403

CARLUCCI, AGOSTINO 54 ACT
1108 CRUID PARK AVE., AUGUSTA 30904

CARPENTER, JAMES L. 29 OE1 P
6500 VERNON WOODS DR., N.E., ATL. 30328

CARPENTER, R. S. 21 ACT SL
1607-A E. SHOTWELL ST., BAINBRIDGE 31717

CARPENTER, ROBERT H. 47 ACT OBG
2404 13TH ST., COLUMBUS 31906

CARR, ALBERT A. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

CARR, RICHARD D. 29 S PM
3744 PREAKNESS DR., DECATUR 30034

CARRINGTON, KENNETH W. 54 ACT NS
1521 POPE AVE., AUGUSTA 30904

CARRINGTON, LOUIE H. 29 ACT PD
275 CARPENTER DR., N. W., ATLANTA 30328

CARROLL, MICHAEL S. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30062

CARSON, JAMES MAXWELL 29 ACT
340 BOULEVARD, N. E., ATLANTA 30312

CARSON, W. P. 76 ACT SL
P. O. BOX 129, DALTON 30720

CARSWELL, AUGUSTIN S. 54 ACT OR
1407 GWINNETT ST., AUGUSTA 30902

CARSWELL, NELSON S., JR. 42 ACT PD
MEDICAL ARTS CENTER, DUBLIN 31021

CARTER, A. W., JR. 29 ACT FP
4932 PHILLIPS DR., FOREST PARK 30050

CARTER, CURTIS H. 54 ACT I
MEDICAL COLLEGE OF GA., AUGUSTA 30902

CARTER, JAMES A. 29 ACT OTC
35 COLLIER RD., N.W., ATLANTA 30309

CARTER, LEON, JR. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030

CARTER, M. GARY 6 ACT OPH
626 FIRST ST., MACON 31204

CARTER, MARY JO 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

CARTER, OTHA B., JR. 23 ACT SL
1009 N. MONROE ST., ALBANY 31701

CARTER, ROBERT A. 36 ACT
212 HOSPITAL DR., WARNER ROBINS 31093

CARTER, ROBERT F. 11 ACT SL
1020 DRAYTON ST., SAVANNAH 31401

CARTER, ROBERT L. 69 OE5 FP
THOMASTON 30286

CARTER, SANDY B. 29 ACT I
1938 PTREE RD., NW, STE. 1502, AT 30327

CARTER, YANCEY F. 56 ACT FP
1223 E. MCPHERSON, NASHVILLE 31639

CASEY, JESSE F. 29 A P
1929 N. RIDGEWAY RD., N.E., ATLANTA 30329

CASH, TED D. 7C ACT FP
P. O. BOX 846, LAYFAYETTE 30728

CASKIN, CLINTON R.J., JR. 15 ACT U
245 WESTVIEW DR., ATHENS 30601

CASON, WILLIAM M. 29 DE5 OALR
6566 GLENRIDGE DR. N.E., ATLANTA 30328

CASTILLO, ANTONIO R. 7C ACT FP
306 CHICKAMAUGA AVE., ROSSVILLE 30741

CASTILLO, REUBEN 16 ACT FP
P. O. BOX 157, JONESBORO 30236

CASTLE, JOHN RICHARD 22 ACT OBG
231 E. PONCE DE LEON AVE., DECATUR 30030

CASTLE, ROBERT F. 29 ACT PD
272 BOULEVARD, N.E., ATLANTA 30308

CASWELL, ROBERT J., II 59 ACT R
686 S. 8TH ST., GRIFFIN 30223

CATANZARO, MARSHALL J. 29 ACT R
3312 PIEDMONT RD., N. E., ATLANTA 30305

CATES, ROBERT M. 27 ACT OBG
10 HOSPITAL CIRCLE, ROME 30161

CATHCART, DON F. 29 OE5 PD
490 PEACHTREE ST. N.E., ATLANTA 30308

CATO, ROBERT E. 6 ACT R
722 FIRST STREET, MACON 31201

CAUBLE, GEORGE 17 ACT
ACWORTH 30101

CAUBLE, JOHN A. 14 ACT
P. O. BOX 1048, CANTON 30114

CAUDILL, DARRELL R. 29 ACT TS
272 BOULEVARD, N.E., ATLANTA 30312

CAUSEY, ROBERT S., JR. 17 ACT PD
122 CHERRY ST., MARIETTA 30062

CEBULA, JEROME M. 4E ACT PATH
2537 HIGHLAND DR., CONYERS 30207

CENTER, A. H. 11 ACT PN
10 MEDICAL ARTS CENTER, SAVANNAH 31405

CHAIT, DONALD C. 29 ACT I
490 PEACHTREE ST. N.E., ATLANTA 30308

CHALMERS, RIVES 29 ACT P
2905 PEACHTREE RD. N. E., ATLANTA 30305

CHAMBERS, BENJAMIN M. 29 ACT OPH
490 PEACHTREE ST., N.E., ATLANTA 30308

CHAMBERS, J. W. 6E ACT I
307 N. LEWIS ST., LAGRANGE 30240

CHAMBERS, ROY G. 54 ACT P
1423 HARPER ST., AUGUSTA 30902

CHAMBLESS, MIRIAM WALKER 45 ACT FP
HAMILTON 31811

CHAMBLESS, WILLIAM G. 45 ACT FP
HAMILTON 31811

CHANDLER, A. BLEAKLEY 54 ACT
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

CHANDLER, JOHN L. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904

CHANDLER, NEAL W. 29 ACT R
3312 PIEDMONT RD., N. E., ATLANTA 30305

CHANG, LUNG-HSIUNG 22 ACT OPH
1300 W. PIKE PL., LAWRENCEVILLE 30245

CHANEY, RALPH H., JR. 3C ACT ANES
P.O. BOX 776, BRUNSWICK 31520

CHANNA, G. H. 22 ACT PD
4705 LAWRENCEVILLE HWY., LILBURN 30247

CHAPPELL, AMEY 29 DE5 I
3750 PEACHTREE ST., N.E., ATLANTA 30319

CHASE, JERRY S. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

CHASTAIN, GEORGE M. 23 ACT ANES
P. O. BOX 1826, ALBANY 31702

CHASTAIN, J. B. 47 ACT PD
1710 HILTON AVE., COLUMBUS 31906

CHEATHAM, JAMES S. 76 ACT P
201 S. HAMILTON ST., STE 408, DALTON 30720

CHELTON, ALICE G. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

CHELTON, L. GUY 29 ACT I
1999 CLIFF VALLEY WAY, N.E., ATLANTA 30329

CHEN, ER-WEI 58 ACT FP
DRS. MEDICAL CENTER, EDISON 31748

CHENEY, HUDDIE L. 65 ACT I
P.O. BOX 1099, THOMASVILLE 31792

CHENG, YUNG-SHENG 54 ACT CBG
TALMADGE MEM. HOSP., AUGUSTA 30902

CHEVES, H. L. 29 ACT FP
2726-B FELTON DR., EAST POINT 30344

CHOI, SUN IK 68 ACT ANES
801 CHEROKEE RD., LAGRANGE 30240

CHIPMAN, R. A. 47 ACT SL
PHYSICIANS BLDG., COLUMBUS 31901

CHISHOLM, LEWIS F. 56 ACT FP
ROBBINS CLINIC, HOMERVILLE 31634

CHORCHES, MICHAEL A. 29 ACT C
265 IVY ST., N.E., ATLANTA 30303

CHRISTIAN, J. D., JR. 54 ACT CR
1521 ANTHONY RD., AUGUSTA 30904

CHRISTMAS, JOSEPH T. 26 ACT FP
VIENNA 31092

CHRISTENSEN, EUNICE H. 65 R ANES
J. D. ARCHBOLD HOSP., THOMASVILLE 31792

CHRISTENSEN, EVERETT D. 65 ACT FP
J. D. ARCHBOLD HOSP., THOMASVILLE 31792

CHRISTOPHER, PHILIP E. 22 ACT SL
365 WINN WAY, DECATUR 30032

CHRISTY, JAMES H. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

CHUNG, SOONG PYO 42 ACT PATH
VA CENTER, DUBLIN 31021

CHYATTE, SAMUEL B. 29 ACT PM
EMORY UNIV. HOSP., ATLANTA 30322

CIBELLI, LOUIS A. 29 S RET
257 COLONIAL HOMES DR.,N.W., ATLANTA 30309

CIRINCIONE, V. J. 11 ACT D
46 MEDICAL ARTS CENTER, SAVANNAH 31405

CLABBY, JAMES W. 17 ACT I
1642 MULKEY RD., S.W., AUSTELL 30001

CLAIBORNE, T. STERLING 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

CLAIR, ALVIN F. 29 ACT D
4720 OLD VILLAGE LN., N.E., ATLANTA 30341

CLARK, F. B. 17 ACT FP
AUSTELL 30001

CLARK, JAMES E. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

CLARK, NEWTON T., JR. 29 ACT CR
275 CARPENTER DR., N.E., ATLANTA 30328

CLARK, NILE R. 15 ACT FP
1160 PRINCE AVE., ATHENS 30601

CLARK, PATRICIA D. 54 I&R
MCG, BOX B98, AUGUSTA 30902

CLARK, REMER Y., JR. 17 ACT FP
1422 CHEROKEE ST., MARIETTA 30062

CLARK, ROLAND B. 30 ACT OPH
2705 WILDWOOD DR., BRUNSWICK 31520

CLARK, SARAH L. 54 ACT I
1280 MERRY STREET, AUGUSTA 30904

CLARK, SPURGEON WM., JR. 72 ACT CPH
P. O. BOX 951, WAYCROSS 31501

CLARK, WILLIAM L., JR. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904

CLARKE, GEORGE D. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

CLARY, THOS. L., JR. 54 ACT I
712 OBERLIN ROAD, AUGUSTA 30904

CLARY, W. UPTON 11 ACT NS
22 MEDICAL ARTS CENTER, SAVANNAH 31405

CLAY, CALDER B., JR. 6 ACT SL
724 HEMLOCK ST., MACON 31201

CLAY, HENRY T. 6 ACT FP
1640 COLEMAN AVE., MACON 31201

CLAY, JAMES R. 15 ACT PATH
ATHENS GENERAL HOSPITAL, ATHENS 30601

CLAYTON, EDWARD C. 2 ACT R
BOX 231, IRWINTON 31042

CLAYTON, MAX L. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405

CLEMENTS, FRED N. 56 ACT FP
ADEL 31620

CLEMENTS, J.L., JR. 29 ACT I
4055 RANDALL MILL RD., N.W., ATL. 30327

CLEMENTS, STEPHEN D. 29 ACT I
1365 CLIFTON RD., N.E., ATLANTA 30322

CLEMONS, THURMAN 8 ACT FP
P. O. BOX 821, STATESBORO 30458

CLIFTON, BEN F. 29 DES SL
4130 N. BROADLAND RD., N.W., ATLANTA 30305

CLINE, PETER J. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

CLINE, STEVEN G. 29 ACT G
1170 CLEVELAND AVENUE, EAST POINT 30344

CLINKSCALES, GRADY S. JR. 29 ACT CR
478 PEACHTREE ST., N.E., ATLANTA 30308

CLONTS, W. T. 17 ACT R
70 TOWER RD., MARIETTA 30001

CLOUSE, JOHN E., JR. 59 ACT FP
682 S. 8TH ST., GRIFFIN 30223

COATES, GRAHAM 23 ACT P
1112 N. MADISON, ALBANY 31705

COBB, CLAUD P., JR. 29 ACT FP
REG. HOSP., N.W., GA., ROME 30161

COBB, ELLIOTT A. 11 ACT
P. O. BOX 6688, STAT C, SAVANNAH 31405

COBBS, BEVERLY W., JR. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

COBERLY, JAMES CHAPMAN 29 S I
1670 CLAIRMONT RD., N. E., ATLANTA 30329

COCHRAN, E. B. 17 ACT SL
641 CHURCH ST., MARIETTA 30060

COCHRAN, T. A. 70 ACT FP
RINGGOLD 30736

CODINGTON, ARTHUR B. 22 ACT I
2644 CANDLER PKWY., DECATUR 30032

COE, F. M. 30 ACT CR
2601 PARKWOOD DR., BRUNSWICK 31520

COFER, OLIN S. 29 DES G
735 PIEDMONT AVE. N. E., ATLANTA 30308

COFFSKY, JAY S. 22 ACT R
755 COLUMBIA CR., DECATUR 30030

COGDELL, B. H. 18 ACT FP
ALMA 31510

COGGINS, ROBERT P. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30060

COHENOUR, JEFFREY H. 15 ACT PATH
RT. 1-136 BOLTON ST., MONROE 30655

COHEN, DAVID M. 29 ACT CTC
6500 VERNON WOODS DR., N.E., ATLANTA 30328

COHEN, I. R. 29 ACT PD
950 W. PEACHTREE ST. N. E., ATLANTA 30309

COHEN, LARRY 15 ACT R
33 SW UPPER RIVERDALE RD., RIVERDALE 30274

COHEN, LAWRENCE 29 ACT OBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

COHEN, MARSHALL 29 ACT D
490 PEACHTREE ST., N.E., ATLANTA 30308

COHEN, MARVYN D. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901

COHEN, PAUL G. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

COHEN, RICHARD W. 17 ACT GR
1676 MULKEY RD., AUSTELL 30001

COHEN, ROBERT A. 29 ACT I
2250 WINDY HILL RD., MARIETTA 30062

COHEN, SHELDON B. 29 ACT P
401 PEACHTREE ST. N. E., ATLANTA 30308

COHN, PERRY L. 6 ACT NS
740 HEMLOCK ST., MACON 31201

COKER, GRADY N. 14 DES SL
CANTON 30114

COLDITZ, RICHARD B. 10 ACT CBG
115 HOSPITAL DR., CARROLLTON 30117

COLEMAN, BLANCHE D. 54 ACT CBG
1450 ANTHONY RD., AUGUSTA 30904

COLEMAN, FRED J. 42 ACT SL
106 N. CHURCH ST., DUBLIN 31021

COLEMAN, OTHA K. 26 ACT FP
CORDELE 31015

COLEMAN, REESE C., JR. 29 ACT L
401 PEACHTREE ST. N. E., ATLANTA 30308

COLEMAN, W. E. 50 ACT FP
HAWKINSVILLE 31036

COLEMAN, WILLIAM MCL. 23 ACT CR
810 14TH AVE., ALBANY 31705

COLES, CLED P., JR. 29 ACT SL
2945 STONE HOGAN RD., CONN. ATLANTA 30331

COLES, W. C. 29 ACT R
3707 PEACHTREE RD., N.E., ATLANTA 30319

COLIER, HOWARD J. 29 ACT C
6287 FAIRBURN RD., DOUGLASVILLE 30134

COLLIER, HAL F. 29 ACT R
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

COLLINGS, HAROLD, JR. 54 ACT N
1514 ANTHONY RD., AUGUSTA 30904

COLLINS, BRASWELL E. 6 ACT CPH
2635 STANISLAUS CIR., MACON 31204

COLLINS, CHAPPELL A., JR. 23 ACT FP
806 14TH ST., ALBANY 31705

COLLINS, FRANK B. 47 ACT SL
MEDICAL ARTS BLDG., COLUMBUS 31901

COLLINS, JAMES E. 45 ACT FP
129 E. SECOND STREET, MANCHESTER 31816

COLLINS, LEWIS R. 13 TI
P. O. BOX 609, NEWNAN 30263

COLLINS, MYRON D. F. 54 ACT CR
1132 CRUID PARK DR., AUGUSTA 30904

COLLINS, ROBERT A. 61 ACT SL
212 REESE ST., AMERICUS 31709

COLLINS, WILLIAM C. 29 ACT OR
275 CARPENTER DR., N. E., ATLANTA 30328

COLMERS, RUDOLF A. 11 ACT I
217 E HUNTINGDON ST., SAVANNAH 31401

COLQUITT, ALFRED O., JR. 17 ACT CBG
1205 ROSWELL ST., MARIETTA 30062

COLQUITT, ALFRED O., III 17 ACT CR
732 CHEROKEE ST., MARIETTA 30060

COLQUITT, HUGH S. 17 ACT
615 ROSWELL STREET, MARIETTA 30062

COLVIN, RICHARD S. 22 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322

CONGER, A. B. 47 ACT SL
206 DOCTORS BLDG., COLUMBUS 31901

CONGER, P. D. 19 ACT FP
MOULTRIE 31768

CONN, LEE R. M. 47 ACT SL
1914 8TH AVE., COLUMBUS 31904

CONNELL, H. C. 6 ACT R
MACON HOSP., MACON 31201

CONNELL, H. R., JR. 27 ACT CALR
HARBIN CLINIC, ROME 30161

CONNER, D. H. 50 ACT
P. O. BOX 629, EASTMAN 31023

CONNER, GEORGE R. 47 ACT SL
1914 8TH AVE., COLUMBUS 31901

CONNER, H. I. 57 ACT SL
P. O. BOX 1107, VIDALIA 30474

CONNER, WILLIAM C. 22 ACT P
755 COLUMBIA CR., DECATUR 30030

CONNOR, ROBERT T. 27 ACT FP
101 JOHN MADDOX DR., ROME 30161

CONOLEY, KENNETH 60 ACT PO
304 N. SAGE, TOCCOA 30577

CONRAD, CONSTANCE C. 29 A FP
1069 BURTON DR., N.E., ATL 30329

COOK, ARTHUR J. 29 ACT R
478 PEACHTREE ST., N. E., ATLANTA 30308

COOK, DANA F. 29 ACT ANES
1000 JOHNSON FERRY RD., N. E., ATL. 30305

COOK, ROGER P. 29 ACT CTC
104 UTICA SQ. MED. CTR., TULSA, OK 74114

COOK, TERRENCE J. 54 ACT A1
1715 1/2 CENTRAL AVE., AUGUSTA 30904

COOK, WM. C., JR. 29 ACT ANES
3113 FARMINGTON DR., N.E., ATLANTA 30339

COOLEY, SARAH F. 29 A
3686 CREEKVIEW CIR., STONE MOUNTAIN 30083

COOLEDGE, JOHN W. 29 ACT PO
4770 N. PEACHTREE RD., CHAMBLEE 30341

COONEY, JAMES P. 29 R
3653 N. STRATFORD RD., N.E., ATLANTA 30305

COOPER, CHARLES F., JR. 29 RET CPH
1851 COLLAND CR., N. W., ATLANTA 30318

COOPER, FLOYD C., III 59 ACT P
ROUTE 4, BOX 309, GRIFFIN 30223

COOPER, FLOYD R., JR. 29 ACT NS
2718 FELTON DR., EAST POINT 30344

COOPER, GERALD R. 29 S I
CDC CENTER, ATLANTA 30333

COOPER, HARRY A. 29 ACT I
3393 PTREE RD., N.E., ATLANTA 30326

COOPER, JAMES T. 17 ACT FP
2480 WINDY HILL RD., MARIETTA 30062

COOPER, JERRY L. 22 ACT
3300 MEMORIAL DR., DECATUR 30033

COOPER, LAWRENCE E. 29 ACT HE
2540 WINDY HILL RD., MARIETTA 30060

COOPER, R. DALE, JR. 29 ACT R
1474 HANOVER W. DR., N. W., ATLANTA 30327

COPELAN, ELTON L. 60 ACT OBG
TOCCOA CLINIC, TOCCOA 30577

COPELAND, FRANK H. 6 ACT P
MED. CTR. OF CENTRAL GA., MACON 31208

COPELAND, H. J. 59 OE1 SL
615 E. COLLEGE ST., GRIFFIN 30223

COPELAND, ROBERT B. 68 ACT I
303 SMITH ST., LAGRANGE 30240

COPPEDGE, W. W. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344

CORDER, V. WOODARD 29 ACT ANES
2367 HENDERSON MILL CT., ATLANTA 30345

CORLEY, C. C. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

CORNWELL, WILLIAM O. 47 A
P. O. BOX 951, COLUMBUS 31902

CORPE, R. F. 27 ACT SL
BATTEY STATE HOSP., ROME 30161

CORRY, ROBERT O. 47 I&R A
MEDICAL CENTER, COLUMBUS 31902

CORTES, JULIO P. 29 ACT ANES
384 PEACHTREE ST., N. E., ATLANTA 30308

COSTA, CONRADO V., JR. 11 ACT FP
P. O. BOX 9787, SAVANNAH 31402

COTTS, LEONARD L. 22 ACT I
3648 CHAMBLEE TUCKER RD., ATLANTA 30341

COUNCIL, BENJAMIN P. 76 ACT OTO
1305 BROADRICK DR., DALTON 30720

COURSON, HERMAN C. 65 ACT I
P. O. BOX 1939, THOMASVILLE 31792

COUSINS, ALBERT L. 68 S I
303 SMITH ST., LAGRANGE 30240

COUSINS, WILLIAM L. 29 DE5 I
1665 COOLEDGE RD., TUCKER 30084

COUSINS, WM. L. 17 ACT I
792 CHURCH ST., MARIETTA 30060

COWAN, MORGAN A. 6 ACT NS
740 HEMLOCK ST., MACON 31201

COWAN, Z. S. 29 OE3 FP
1179 CLIFTON ROAD, N. E., ATLANTA 30316

COWART, CHARLES T. 68 ACT SL
718 LA ROSE TERR., LAGRANGE 30240

COWART, G. THOMAS 29 ACT L
384 PEACHTREE ST. N. E., ATLANTA 30308

COX, CHARLOTTE T. 6 ACT OBG
380 HOSPITAL DR., MACON 31201

COX, ROSS J. 29 ACT FP
6363 ROSWELL RD., N.E., ATLANTA 30328

COXWELL, WAYNE L. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001

CRAIG, FREDERICK S. 47 OE1 GR
NO CURRENT ADDRESS

CRAIG, JAMES B. 2 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31062

CRANK, R. PAUL 22 ACT I
755 COLUMBIA DR., DECATUR 30030

CRANMAN, JERARD S. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033

CRANSTON, W. J. 54 DE5 I
2749 WALTON WAY, AUGUSTA 30904

CRARY, ELY J. 17 ACT CPH
4730 AUSTELL RD., AUSTELL 30001

CRAVER, JOE M. 29 ACT TS
25 PRESCOTT ST., N.E., ATLANTA 30308

CRAWFORD, CARL L. 36 ACT FP
1410 WATSON RD., WARNER ROBINS 31093

CRAWFORD, CLYDE L. 29 ACT SL
652 W. PEACHTREE ST. N. W., ATLANTA 30308

CRAWFORD, GLENN C. 17 ACT R
COBB GENERAL HOSP., AUSTELL 30001

CRAWFORD, JOHN B. 59 ACT FP
BARNESVILLE 30204

CRAWLEY, WILLIAM O. 70 ACT OBG
787 CHICKAMAUGA AVE., ROSSVILLE 30741

CREAGH, GERARD B. 15 DE1 PH
555 MILLEDGE CIR., ATHENS 30601

CREECH, EARL L. 56 ACT OR
P. O. BOX 2261, VALDOSTA 31601

CRENSHAW, JOHN T. 37 ACT FP
P. O. BOX 219, JEFFERSON 30549

CRIDER, HARRY J., JR. 29 ACT OBG
1135 SHERIDAN RD., N. E., ATLANTA 30324

CRIMMINS, L.T. 23 ACT SL
1009 N. MONROE, ALBANY 31701

CRISLER, EUGENE C. 54 ACT R
3623 J. DEWEY GRAY CIRCLE., AUGUSTA 30904

CRISP, NELIDA S. 29 S SL
3233 BUFORD HWY., N.E., ATLANTA 30329

CRISPIN, ROY H. 22 ACT TS
365 WINN WAY, DECATUR 30030

CROFT, THOMAS J. 29 ACT NS
2718 FELTON DR., EAST POINT 30344

CRONCE, PAUL C. 29 ACT O
1293 PEACHTREE ST., N. E., ATLANTA 30309

CROSBY, WILLIAM V. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601

CROSS, JAMES LEE 29 ACT OBG
340 BOULEVARD, N.E., ATLANTA 30312

CROUCH, MICKEY M. 54 DE2 FP
MEDICAL COLLEGE OF GA., AUGUSTA 30902

CROW, ROBERT W. 29 ACT PL
1938 PEACHTREE RD., N.W., ATLANTA 30309

CROWDER, JACKSON G. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

CROWOIS, JAS. HUDSON, JR. 58 ACT
BLAKELY 31723

CRUISE, JOE S. 29 ACT PLL
384 PEACHTREE ST. N. E., ATLANTA 30308

CRUMBLEY, A. J., JR. 29 ACT SL
2788 BAYARD ST., EAST POINT 30344

CRUMP, HOYT W. 28 ACT FP
1196 JEFFERSON AVE., EAST POINT 30344

CRUTCHER, JAMES CARROLL 29 S
1670 CLAIRMONT RD., N.E., DECATUR 30033

CRYMES, JOHN M. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAV 31405

CUETO, JOSE R. DEL 29 ACT FP
2739 FELTON DR., EAST POINT 30344

CULBRETH, ERNEST W. 27 ACT FP
319 W. 6TH ST., ROME 30161

CUMMINGS, ROBERT J., JR. 29 A OR
300 BOULEVARD, N.E., ATLANTA 30312

CUMMINGS, T. E. 27 ACT FP
121 E. MAPLE ST., ROCKMART 30153

CUNDEY, DAVID W. 54 ACT C
1003 CHAFFEE AVE., AUGUSTA 30904

CUNDEY, PAUL E., JR. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904

CUNNINGHAM, ROBERT P. 29 ACT I
SOUTHERN BEL. TEL.&TEL.,BOX 2211,ATL 30301

CURETON, M. K. 70 DE5 PH
6 SUNSET DR., LAFAYETTE 30727

CURETON, RICHARD K. 70 ACT R
HUTCHESON HOSP., FT. OGLETHORPE 30742

CURIEL, HECTOR J. 17 ACT FP
MEDICAL BLDG., DALLAS 30132

CURRY, LEON E. 8 ACT FP
P. O. BOX 267, METTER 30439

CURRY, VIRGIL L. 17 ACT U
2404 AUSTELL-MARIETTA RD., ALSTELL 30001

CURTIS, EARNEST M., JR. 29 ACT OBG
275 CARPENTER DR., SANDY SPRINGS 30328

CURTIS, JOHN R. 15 ACT P
UNIV. HEALTH SERV., ATHENS 30601

CURTIS, THOMAS H. 70 ACT OBG
219 FIRST ST., FT. OGLETHORPE 30742

CURTIS, WALKER L. 29 OE1 I
P. O. BOX 87100, COLLEGE PARK 30337

CUSTY, JANE C. 54 ACT ANES
MEDICAL COLLEGE OF GA., AUGUSTA 30902

CUTTS, WILLIAM G., JR. 14 ACT SL
CANTON MED. CTR., CANTON 30114

D

DAHLSTROM, SIGURD E. 27 ACT OR
821 TURNER MCCALL BLVD., ROME 30161

DAILY, F. WILLSON 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405

DAITCH, RONALD 54 ACT OBG
1021-15TH ST., AUGUSTA 30901

DALLAS, R. E. 69 ACT FP
211 E. THOMASTON ST., THOMASTON 30286

DALLAS, WM. M., JR. 69 ACT SL
405 W. MAIN ST., THOMASTON 30286

DALRYMPLE, DAVID E. 29 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

DALTON, WILLIAM E. 31 ACT FP
105 E. 40TH DR., CALHOUN 30701

DALY, FRANK T., JR. 22 ACT R
755 COLUMBIA DR., DECATUR 30030

DANEMAN, E. A. 72 ACT
P. O. DRAWER 152, GAMBIER, OHIO 43022

DANIEL, A. B. 8 ACT SL
P. O. BOX 717, STATESBORO 30458

DANIEL, ERNEST F., JR. 54 ACT NS
2247 WRIGHTSBORO RD., AUGUSTA 30904

DANIEL, JOE W., JR. 6 ACT
1383 OGLETHORPE ST., MACON 31201

DANIEL, WM. W. 29 ACT OBG
5675 PTREE-DUNWOODY RD., N.E. ATL 30342

DANIELL, DUREN 36 DE2 FP
4573 N. BEECHWOOD DR., MACON 31204

DANIELS, CHARLES W. 29 DE5 OBG
1647 N. ROCK SPRINGS RD., ATLANTA 30324

DANZIG, LAMONT EARL 11 ACT I
P. O. BOX 5086, SAVANNAH 31403

DARBY, V. L. 57 DE5 SL
706 CHURCH ST., VIDALIA 30474

DARNELL, D. T. 14 ACT FP
TATE 30177

DASHIELL, WAVERLY B. 47 ACT CBG
P. O. BOX 157, COLUMBUS 31902

DAVENPORT, T. F. 2S DE5 PD
478 PEACHTREE ST., NE, ATLANTA 30308

DAVIDSON, GENE G. 27 ACT I
HARBIN CLINIC, ROME 30161

DAVIDSON, EUGENE O. 2S ACT SL
1365 CLIFTON RD.,N.E.,ATLANTA 30322

DAVIDSON, JOHN K., III 2S ACT I
69 BUTLER ST., S.E., ATLANTA 30303

DAVIES, NICHOLAS E. 2S ACT I
35 COLLIER RD., N.W., ATLANTA 30309

DAVIES, ROBERT L. 22 ACT R
755 COLUMBIA CR., DECATUR 30030

DAVIS, ALBERT M. 2S ACT I
75 PIEDMONT AVE., N.E., ATLANTA 30303

DAVIS, ALFRED L., JR. 72 ACT PD
P. O. BOX 71, BLACKSHEAR 31516

DAVIS, BILLY J. 2E ACT FP
GIBSON ST., HARTWELL 30512

DAVIS, BYRON S. 56 ACT PATH
P. O. BOX 2564, VALDOSTA 31602

DAVIS, DAVE M. 2S ACT P
1999 CLIFF VALLEY WAY, N.E., ATLANTA 30329

DAVIS, FELTZ C. 6 DE5 ALR
745 PINE ST., MACON 31201

DAVIS, FLOYD E. 72 ACT FP
1921 ALICE ST., WAYCROSS 31501

DAVIS, FLOYD L. O. 2S ACT OPH
2722-A FELTON DR., EAST POINT 30344

DAVIS, F. MORRIS 66 ACT FP
820 TIFT AVE., TIFTON 31794

DAVIS, H. G., JR. 7S ACT FP
SYLVESTER 31791

DAVIS, JAKE E. 2S ACT ANES
69 BUTLER ST., N.E., ATLANTA 30303

DAVIS, JOHN L., III 2S ACT OPH
3200 HOWELL MILL RD.,N.W., ATL. 30327

DAVIS, JOSEPH R. 2S ACT FP
6701 ROSWELL RD., N. E., ATLANTA 30328

DAVIS, LAWRENCE P. 4 ACT SL
P.O. BOX 764, CARTERSVILLE 30120

DAVIS, M. BEDFORD, JR. 2S ACT SL
340 BOULEVARD N.E., ATLANTA 30312

DAVIS, MARVIN L. 2S ACT PD
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

DAVIS, MATTHEW E. 16 ACT CALR
33 S.W. UPPER RVRDALE RD., JONESBORO 30274

DAVIS, RALPH J. 27 ACT SL
P. O. BOX 2227, ROME 30161

DAVIS, R. CARTER, JR. 2S ACT I
1201 PTREE ST., N.E., ATLANTA 30361

DAVIS, ROBERT S. 2S ACT OBG
2100 PARKLAKE DR., N. E., ATLANTA 30345

DAVIS, SHELLEY C., JR. 2S ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

DAVIS, TERRELL L. 66 ACT PD
714 E. 18TH ST., TIFTON 31794

DAVIS,THOMAS A. 2S ACT P
1999 CLIFF VALLEY WAY, ATL. 30329

DAVIS, THOMAS NED 6 ACT FP
IRWINTON 31042

DAVIS, WILKES H., JR. 17 ACT OPH
653 CHEROKEE ST., N. E., MARIETTA 30060

DAVIS, WILLIAM A., III 2S ACT R
35 LINDEN AVE., N. E., ATLANTA 30308

DAVIS, WILLIAM B. 2S R PD
2065 WALKER AVE., COLLEGE PARK 30337

DAVIS, WILLIAM S. 2S ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

DAVIS, WILLIAM S. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001

DAVISON, ALEXIS H. 2S ACT I
478 PEACHTREE ST., N. E., ATLANTA 30308

DAWSON, JACK E., JR. 2S DE4 I
2225 RIADA DR., N.W., ATLANTA 30305

DEAL, ALBERT M. E ACT SL
P. O. BOX 647, STATESBORO 30458

DEAL, HELEN R. E ACT PD
P. O. BOX 647, STATESBORO 30458

DEAL, JOHN D. 8 ACT FP
P. O. BOX 1043, STATESBORO 30458

DEAN, ROBERT D. 47 ACT OBG
110 DOCTORS BLDG., COLUMBUS 31901

DE ARMAS, F. M. 2S ACT ANES
2760-B FELTON DR., EAST POINT 30344

DEAS, RALPH H. 2S DE1 OPH
3166 MAPLE DR., ATLANTA 30305

DEATON, J. H. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

DEEN, JOHNNY T. 69 ACT OPH
THOMASTON 30286

DEES, HOYT C. 2S ACT OBG
401 PEACHTREE ST., N. E., ATLANTA 30308

DEFOOR, JOSEPH T., JR. 17 ACT ANES
754 CHEROKEE ST., MARIETTA 30060

DEITCH, MILTON J. 2S ACT L
490 PEACHTREE STREET, N.E., ATLANTA 30308

DEKLE, JOHN L., JR. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31405

DELANCY, HERMAN 11 ACT SL
5102 PAULSEN ST., SAVANNAH 31405

DE LA PERRIERE, ARMAND 2S ACT OBG
3626 CHAMBLEE TUCKER RD, CHAMBLEE 30341

DELASHMUTT, ROBERT E. 2S ACT PATH
340 BOULEVARD, N.E., ATLANTA 30312

DELATORRE, JOSE M. 2 ACT P
153 RIVERSIDEDR., MILLEDGEVILLE 31061

DELGADO, JOSE A. 2 ACT P
COLLEGE ST., MONTICELLO 31064

DELLINGER, RAIDEN W. 27 ACT SL
321 W. 7TH ST., ROME 30161

DELLINGER, RAY E. 17 ACT SL
3001 S. COBB DR., S. E., SMYRNA 30080

DEL RIO, GABRIEL G. 11 ACT PD
P. O. BOX 6688, SAVANNAH 31405

DEMBY, CHARLES E. 2S ACT SL
6646 CHURCH ST., DOUGLASVILLE 30134

DEMPSEY, JAMES E. 15 ACT OTC
1010 PRINCE AVE., ATHENS 30601

DENIS, BRUNO 2S ACT FP
427 KING ARNOLD DR., HAPEVILLE 30354

DENMARK, L. D. 2S DE5 PD
5605 GLENRIDGE DR. N. E., ATLANTA 30305

DENNEY, RDY L. 10 ACT CALR
CARROLLTON 30117

DENNIS, ALLEN J., JR. 54 ACT I
TALMADGE MEM. HOSP., AUGUSTA 30902

DENNIS, BROWN W. 2S ACT I
1938 PEACHTREE ST., N. W., ATLANTA 30309

DENNISON, DAVID B. 2S ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

DENSLER, JAMES F. 2S ACT SL
319 W. LAKE AVE., ATLANTA 30318

DE REAMER, JOHN W. 11 DE1 D
121 E. JONES ST., SAVANNAH 31401

DEREBAIL, GOPALAKRISHNA 6 ACT EM
4923-F RIVOLI DR., MACON 31204

DERISO, H. CLARK 11 ACT OR
44 MEDICAL ARTS CENTER, SAVANNAH 31405

DERRICK, HOWARD C., JR. 7C ACT FP
LAFAYETTE 30728

DEVORE, MARGARET B. 54 ACT ANES
MED. COLL. OF GA., AUGUSTA 30902

DEW, J. HARRIS 2S ACT SL
3250 HOWELL MILL RD., N.W., ATLANTA 30327

DEW, J. HARRIS, JR. 2S ACT OPH
3158 MAPLE DR., N. E., ATLANTA 30305

DI BENEDETTO, ROBERT J. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405

DICKENS, C. H. 4S DE5 PD
903 DIXIE AVE., MADISON 30650

DICKENS, WINBURN J. 3 ACT FP
802 EAST AVE., WINDER 30680

DICKEY, L. E., JR. 6 ACT OR
380 HOSE DR., MACON 31201

DICKINSON, JOHN I. 27 ACT SL
310 W. SIXTH ST., ROME 30161

DICKINSON, RICHARD F. 23 ACT R
P.O. BOX 1924, ALBANY 31702

DICKSON, WILLIAM A. 56 ACT FP
408 E. STANFILL, FAHIRA 31632

DILIBERTI, CHARLES P. 6 ACT R
4754 OXFORD RD., MACON 31204

DILLARD, GARY A. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

DILLARD, WILLIAM B., JR. 4 ACT FP
P. O. BOX 468, CARTERSVILLE 30120

DIMON, JOS. H. III 2S ACT OR
1938 PEACHTREE RD., N.W., ATLANTA 30309

DIMOND, KEITH A. 11 ACT NE
P. O. BOX 5086, SAVANNAH 31405

DINNERSTEIN, ALLAN J. 2S ACT OBG
259 ARROWHEAD BLVD., JONESBORO 30236

DISMUKE, JAMES C. 56 ACT FP
P. O. BOX 409, ADEL 31620

DIXON, ELLIS F., JR. 15 ACT OBG
1010 PRINCE AVENUE, ATHENS 30601

DIXON, HAMILTON S. 27 ACT ALR
15 JOHN MADDOX DR., ROME 30161

DIXON, JOHN M. 22 ACT OPH
12 LAVISTA PER. OFF. PK., TUCKER 30084

DIXON, P.K. 34 ACT SL
1114 VINE ST., N.E., GAINESVILLE 30501

DIXON, SAMMIE 66 ACT OBG
1493 KENNEDY RD., TIFTON 31794

DIXON, WILLIAM L. 54 ACT SL
MCG, DEPT. SURGERY, AUGUSTA 30902

DOBES, WILLIAM L., JR. 2S ACT D
478 PEACHTREE ST., N.E., ATLANTA 30308

DODD, JOHN S., JR. 2S ACT I
65 COLLIER RD., N.W., ATLANTA 30309

DODD, WILLIAM ASA 42 ACT FP
P.O. BOX 257, WRIGHTSVILLE 31096

DODELIN, R. A. 47 ACT
2300 MANCHESTER RD.,STE. E1,COLUMBUS 31904

DODGEN, CHARLES W. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

DOLAN, JOSEPH A. 6E ACT OBG
311 S. LEWIS ST., LAGRANGE 30240

DOMINGOS, WM. R. 6 ACT PD
187 PIERCE AVE., MACON 31204

DOMINY, DALE E. 2S S SL
3988 ASHENTREE DR., ATLANTA 30341

DONNER, ROBERT S. 6 ACT PATH
P. O. BOX 6000 , MACON 31208

DOOLAN, JOHN J., JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401

DOOLEY, WILLIAM D. 27 ACT R
P. O. BOX 2625, ROME 30161

DORNEY, EDWARD R. 2S ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322

DOSS, MELVIN C. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577

DOUGLASS, THOMAS G. 54 ACT I
1407 GWINNETT ST., AUGUSTA 30902

DOVE, DONALD V. 13 ACT
44 S. CLAYTON ST., LAWRENCEVILLE 30245

DOWDA, F. W. 2S ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

DOWLING, GEORGE BRACKETT 2S DE5 I
1 WEST COURT SQ., STE. 300, DECATUR 30030

DOWMAN, CHARLES E. 2S ACT NS
478 PEACHTREE ST. N.E., ATLANTA 30308

DOWMAN, CORDELIA K. 2S A PD
2550 BROOKDALE DR., NW, ATLANTA 30305

DOWNEY, W. P. 10 ACT FP
TALLAPODSA 30176

DOWNING, EDWARD F. 11 ACT NS
22 MEDICAL ARTS CTR., SAVANNAH 31405

DOXEY, CLEM M., JR. 17 ACT O
114 CHERRY ST., SUITE E, MARIETTA 30060

DRAKE, CHAS. F. 57 ACT FP
121 N. CASWELL, GLENNVILLE 30427

DRAKE, HENRY C. 16 ACT FP
PEACHTREE CITY, 30214

DRESSLER, MARIAN S. 22 DE2 PH
777 HOUSTON MILL RD., N.E., 5, ATL 30329

DRURY, CARL M. 24 ACT FP
304 OSBORNE ST., ST. MARYS 31558

DRURY, WILEY L. 56 ACT ANES
P.O. BOX 1727, VALDOSTA 31601

DUARTE, CARLOS R. 22 ACT PD
365 WINN WAY, DECATUR 30030

DUBOIS, RICHARD E. 29 ACT I
478 PEACHTREE ST., N.E., ATLANTA 30308

DUBOSE, BOLLING S., JR. 15 ACT I
225 S. MILLEDGE, ATHENS 30601

DUBOSE, LIGE MOULTRIE 17 ACT
1205 ROSWELL STREET, MARIETTA 30062

DUDLEY, A. B., JR. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

DUDLEY, A. G. 61 DE4 OBG
205 S. LEE ST., AMERICUS 31709

DUDLEY, JAMES C. 61 ACT SL
629 E. FORSYTH ST., AMERICUS 31709

DUGGAN, A. DAN 7E ACT FP
P. O. BOX 370, WASHINGTON 30673

DUGGAN, C. A., JR. 6 ACT FP
380 HOSP. DR., MACON 31201

DUHON, FRED J. 7C ACT FP
DOCTORS CLINIC, LAFAYETTE 30728

DUKE, GRADY F. 59 ACT SL
303 SOUTH 8TH ST., GRIFFIN 30223

DUKE, JOHN F., III 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030

DULL, MARTHA KATHERINE 22 ACT OBG
4330 LAVISTA RD., TUCKER 30084

DULOCK, MALCOLM P. 29 ACT FP
1000 S. BUFORD HWY., NORCROSS 30071

DUMAIS, ALCID F. 39 ACT SL
1067 PEACHTREE ST., LOUISVILLE 30434

DUNAGAN, DONALD 54 ACT PD
GRACEWOOD STATE HOSP., GRACEWOOD 30812

DUNAWAY, JAMES BOYD 59 ACT PD
712 S. 8TH STREET, GRIFFIN 30223

DUNAWAY, MARSHALL C. 65 ACT I
900 GORDON AVE., THOMASVILLE 31792

DUNBAR, ERNEST A., JR. 29 ACT PD
1035 MAIN ST., FOREST PARK 30050

DUNBAR, RONALD W. 29 ACT ANES
1364 CLIFTON RD., N.E., ATLANTA 30322

DUNBAR, WALTER S. 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308

DUNCAN, G. A. 22 DE5 FP
714 S. CANDLER STREET, DECATUR 30030

DUNCAN, J. HARRY 11 ACT CPH
P.O. BOX 3008, SAVANNAH 31403

DUNCAN, ROY G. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060

DUNLAP, DICKSON B. 54 ACT I
VA HOSP., AUGUSTA 30904

DUNLAP, ERNEST B., JR. 29 DE1 CR
900 ARTWOOD RD., N.E., ATLANTA 30307

DUNN, BYRON H. 22 ACT OBG
2910 N. DRUID HILLS RD., ATLANTA 30329

DUNN, LAURENCE B. 11 DE5 FP
P. O. BOX 205, BLUFFTON, S. C. 29910

DUNN, MAURICE 54 ACT P
3012 PARK AVE., AUGUSTA 30904

DUNN, ROBERT G., JR. 23 ACT R
P.O. BOX 1924, ALBANY 31702

DUNN, WM. R. 13 ACT
P. O. BOX 668, CUMMING 30130

DUNSTAN, EDGAR M. 29 DE5 I
710 PINETREE DR., DECATUR 30030

DUPONT, LOUIS 47 ACT SL
P. O. BOX 4199, COLUMBUS 31904

DUPREE, J. T. 42 S SL
VA CENTER, DUBLIN 31021

DUPREE, THOMAS E. 6 ACT FP
577 WALNUT ST., MACON 31201

DURALDE, FERNANDO U. 29 ACT SL
2760 FELTON DR., EAST POINT 30344

DURDEN, CHARLES F. 5 ACT FP
P. O. BOX 480, FITZGERALD 31750

DURDEN, JOHN G., JR. 47 ACT SL
1915 SEVENTH AVE., COLUMBUS 31901

DURDEN, MARK C., III 6 ACT FP
1383 OGLETHORPE ST., MACON 31201

DURHAM, BON M. 61 DE3 I
142 S. JACKSON ST., AMERICUS 31709

DURHAM, W. P. 50 DE5 GALR
ABBEVILLE 31001

DURISCH, LAWRENCE L. 34 ACT OTO
304 ENOTA DR., GAINESVILLE 30501

DURRENCE, LEONARD C., JR. 72 ACT FP
BLACKSHEAR CLINIC, BLACKSHEAR 31516

DURRETT, DONALD M. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344

DUTTERA, MAURICE J., JR. 6E ACT H
303 SMITH ST., LAGRANGE 30240

DYCKMAN, EDWARD 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322

DYKEN, PAUL R. 54 ACT PDN
MED. COLLEGE OF GA., AUGUSTA 30902

DYNIN, MICHAELA 11 ACT P
P. O. BOX 13007, SAVANNAH 31406

E

EARLE, WALTER C. 22 DE5
2750 REDDING RD., N. E., ATLANTA 30319

EARNEST, DAVID L., LT. 29 DE4 I
7500 E. CARSON ST., LONG BH., CALIF. 90801

EASLEY, CONRAD H. 76 ACT SL
1401 BURLEYSON CR., DALTON 30720

EASLEY, CURRAN S., JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240

EASON, HARMER O., JR. 23 ACT I
207 E. WILLINGHAM, SYLVESTER 31791

EATON, JAMES M., JR. 47 ACT L
DRS BLDG., COLUMBUS 31901

EATON, S. BOYD 29 ACT R
265 IVY ST.,N.E.,ATLANTA 30303

EAVES, ROBERT F., JR. 22 ACT
2390 MAIN ST., TUCKER 30084

EBERHARDT, REESE C. 6 ACT FP
227 ORANGE ST., MACON 31201

EBERHART, CHARLES 29 DE1 L
1738 COUNCIL BLUFF DR., ATLANTA 30345

ECHEMENDIA, MARIANO M. 29 ACT OBG
384 PEACHTREE ST., N.E., ATLANTA 30308

ECHOLS, GEORGE L., JR. 54 ACT PD
1021 15TH ST., AUGUSTA 30901

ECHOLS, JOSEPH M. 54 ACT OBG
1167 UNIVERSITY PL., AUGUSTA 30902

EDENFIELD, R. W. 6 ACT SL
726 FIRST STREET, MACON 31201

EDENFIELD, WILSON T. 29 ACT R
300 BOULEVARD, N.E. ATLANTA 30312

EDGENS, JACK R. 27 ACT
RT. 5 HORSESHOE BEND, ROME 30161

EDMONDSON, H. T., JR. 54 ACT SL
V. A. HOSPITAL, AUGUSTA 30904

EDMONDSON, STEPHEN W. 29 ACT P
5064 NANDINA LN., DUNWOODY 30338

EDMONDSON, T. L. 66 ACT FP
TIFTON 31794

EDWARDS, A. JOSEPH, JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401

EDWARDS, CHARLES H. 29 ACT P
1000 JOHNSON FRY RD., N. E., ATLANTA 30305

EDWARDS, ERNEST G., JR. 11 ACT OR
44 MECICAL ARTS CENTER, SAVANNAH 31405

EDWARDS, F. KATHERINE 22 ACT R
4777 REBEL TRAIL, N.W., ATLANTA 30327

EDWARDS, FRANKLIN D. 47 ACT L
1430 3RD AVE., COLUMBUS 31901

EDWARDS, M. DELMAR 47 ACT SL
804 4TH AVE., COLUMBUS 31901

EDWARDS, PHILIP G. 22 ACT L
960 JOHNSON FRY. RD., STE 420, AT 30342

EDWARDS, WM. T., JR. 29 ACT OPH
1218 W. PACES FRY RD., STE. 104, ATL 30327

EGAN, RICHARD W. 30 ACT SL
2432 PARKWOOD DR., BRUNSWICK 31520

EGAN, ROBERT L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322

EHIK, JULIUS 29 ACT P
811 JUNIPER ST., N.E., ATLANTA 30308

EHRLICH, M.A. 21 DE5 PD
231 E. BROUGHTON ST., BAINBRIDGE 31717

EIDEX, MARSHALL F. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033

EIDEX, MAXWELL A. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033

EIDSON, ROBERT F. 76 ACT OBG
1217 MEMORIAL DR., DALTON 30720

EITH, RONALD E. 22 ACT AL
4511 CHAMBLEE DUNWOODY RD., ATLANTA 30341

ELDER, IVAN R. 10 ACT FP
MEDICAL CLINIC, BREMEN 30110

ELDRIDGE, F. G. 56 ACT R
DOCTORS BLDG., VALDOSTA 31603

ELKINS, JAMES A. 47 DE1 CR
P.O. BOX 5364, COLUMBUS 31906

ELLINGTON, PRESTON DAVID 54 ACT PD
824 WINDSOR CT., AUGUSTA 30904

ELLIOTT, C. B. 27 ACT SL
CEDARTOWN 30125

ELLIOTT, J. L. 11 DE5 I
212 E. HUNTINGDON ST., SAVANNAH 31401

ELLIOTT, RALPH A. 29 A I
STUD HEALTH SERV., GA. TECH, ATLANTA 30308

ELLIS, JOHN O. 29 ACT R
384 PEACHTREE ST., N.E., ATLANTA 30308

ELLIS, RALPH G., JR. 54 ACT ANES
MEDICAL COLLEGE OF GA., AUGUSTA 30904

ELLISON, LOIS T. 54 ACT
TALMACGE MEM. HOSP., AUGUSTA 30902

ELLISON, ROBERT G. 54 ACT TS
MED. COLLEGE OF GEORGIA, AUGUSTA 30904

ELLZEY, B. FRANK 22 ACT OBG
340 BOULEVARD, N. E., ATLANTA 30312

ELLZEY, MILDRED JANE 22 ACT PD
3290 MEMORIAL DR., DECATUR 30032

ELMER, R. A. 29 ACT R
6500 VERNON WOODS DR., N.E., ATLANTA 30328

ELROD, BRUCE A. 7C ACT PATH
823 MCCALLIE AVE., CHATTANOOGA, TN. 37403

ELROD, DAN B. I ACT FP
PROFESSIONAL ARTS CTR., HAZLEHURST 31539

ELSAS, LOUIS J. 29 A PD
EMORY UNIV. SCHOOL OF MED., ATLANTA 30322

ELSEA, WILLIAM R. 29 ACT PH
99 BUTLER ST., SE, ATLANTA 30303

ELSON, EILEEN F. 29 DE1 PATH
78 SHERIDAN DR., N.E. 10, ATLANTA 30305

ELSON, SHIA H. 29 ACT I
3250 POWELL MILL RD., N.W., ATLANTA 30345

ENGEL, M. F. 30 ACT D
3114 SHRINE RC., BRUNSWICK 31520

ENGELHAROT, SAMUEL M.,III 2S ACT CBG
710 PEACHTREE ST., N.E., ATLANTA 30308

ENGLER, HAROLC S. 54 ACT SL
TALMAGGE MEMORIAL HOSPITAL, ALGUSTA 30902

ENGLISH, INMAN C. 3E ACT PD
212 HOSPITAL CR., WARNER ROBINS 31093

ENSLEN, PHILLIP J. 71 ACT FP
247 ALCOVA ST., MONROE 30655

EPPS, GEORGE L. 47 ACT R
THE MEDICAL CENTER, COLUMBUS 31902

EPSTEIN, JACOB 2S ACT CBG
1175 PEACHTREE STREET, NE, ATLANTA 30309

ERBELE, LED A. 6 ACT PATH
BOX 4648, MACON 31208

ERICKSON, PAUL T. 2S A PH
109 PARKWOOD LANE, ATL. 30030

ERKAN, NIZAMI V. 2S ACT PO
2730 FELTON OR., EAST POINT 30344

ERKULVRAWATR, S. 54 ACT N
VA HOSP., AUGUSTA 30904

ERMUTLU, ILHAN M. 11 ACT P
P. O. BOX 119, COLUMBIA, SC 29202

ERWIN, GEORGE 15 ACT PO
1010 PRINCE AVENUE, ATHENS 30601

ERWIN, GOODLOE Y. 15 ACT I
1010 PRINCE AVE., ATHENS 30601

ESENER, ISMAIL 27 ACT CBG
NO CURRENT AOCRESS

ESPINOZA, FRANCISCO T. 2S ACT SL
3065 AUSTELL RO., MARIETTA 30060

ESPY, GOOOMAN B., III 17 ACT CBG
72 PLAZA WAY, MARIETTA 30060

ESTES, EOWARD E., JR. 34 ACT L
290 ENOTA ORIVE, N.E., GAINESVILLE 30501

ESTES, J. W. 22 ACT VS
353 PARKWAY OR., N.E., ATLANTA 30312

ESTES, RICHARC C. 2S ACT L
35 COLLIER RD., N.W., ATLANTA 30309

ETHERIOGE, E. H. 3 ACT FP
WINOER 30680

ETHERIDGE, JOHN G. 6 ACT PATH
BOX 6000, MACON 31208

EUBANKS, OMER L. 2S ACT I
1143 ALPHARETTA ST., ROSWELL 30075

EUBANKS, WM. L. 2S ACT OPH
490 PEACHTREE ST., N.E., ATLANTA 30308

EVANS, ALBERT L. 2S ACT SL
735 PIEOMONT AVE. N. E., ATLANTA 30306

EVANS, OONALO C. 4 ACT FP
NEAMAR VILLAGE, CARTERSVILLE 30120

EVANS, E. C. 2S ACT I
340 BOULEVARO, N. E., ATLANTA 30312

EVANS, J. RUFUS 22 OE5 FP
STONE MOUNTAIN 30083

EVANS, JAMES A. 2S ACT ANES
384 PEACHTREE ST., N.E., ATLANTA 30308

EVANS, JAMES P. 11 ACT PO
5102 PAULSEN ST., NO. 3, SAVANNAH 31405

EVANS, WM. W. 2S OE1 I
450 ROCK SPRINGS RO., N.E., ATLANTA 30324

EVERETT, THEDOORE 54 ACT L
1467 HARPER ST., AUGUSTA 30902

EVERHART, GUY O. 2S ACT FP
1545 LA VISTA RO., N.E., ATLANTA 30329

EVERSOLE, JOSEPH W. 6 ACT PATH
P. O. BOX 6000, MACON 31208

EWING, R. B. 6 ACT O
781 SPRING STREET, MACON 31201

EYRAS, THOMAS E. 15 OE1 FP
208 CT. ST., VERMILLION, S.O. 57069

EYZAGUIRRE, WM. A. 2S ACT C
5064 NANDINA LANE, OUNWOODY 30338

EZZARC, GEORGE P. 13 ACT FP
CROGAN ST., LAWRENCEVILLE 30245

F

FACKLER, WILLIAM B., JR. 6E ACT I
LAGRANGE 30240

FAGIN, RONALD R. 11 ACT I
5102 PAULSEN ST., SAVANNAH 31405

FALBAUM, HARTLEY L. 65 ACT CR
210 W. HANSELL ST., THOMASVILLE 31792

FANCHER, JAMES K. 2S OE5 I
31 MUSCOGEE AVE., N.E., APT. 6, ATL. 30305

FARMER, CHAS. W., JR. 2C ACT CALR
P. O. BOX 609, NEWNAN 30263

FARRELL, ROBERT A. 27 ACT PATH
FLOYO COUNTY HOSP., ROME 30161

FARRIS, JOHN OUNCAN 72 ACT CBG
P. O. BOX 177, WAYCROSS 31501

FARRIS, JOHN J. 3S ACT
BARTOW 30413

FARROW, ROYAL T. 76 ACT PO
ALABAMA ST., DALTON 30720

FARUQUI, A. M. A. 2S A C
549 PATREE ST., APT 703, ATLANTA 30308

FAULKNER, ALVA A. 54 ACT CBG
1503 WINTER ST., AUGUSTA 30904

FAULKNER, ROBERT L. 46 ACT FP
1022 TATE ST., COVINGTON 30209

FEIGENBAUM, ERNEST 2S A PH
U.S.A.I.O., BOX J, BALBOA CANAL ZONE 00101

FEINERMAN, LOIS K. 17 ACT O
1680 MULKEY RC., AUSTELL 30001

FEINERMAN, MICHAEL B. 17 ACT PL
1680 MULKEY RO., AUSTELL 30001

FEINGOLO, ALAN O. 22 A I
1365 CLIFTON RO., N.E., ATLANTA 30322

FELOER, LOUIS H. 2S ACT I
35 COLLIER RD., N.W., ATLANTA 30309

FELOER, RICHARO E. 2S ACT P
6363 ROSWELL RO., N.E., ATLANTA 30328

FELOMAN, OANIEL S. 54 ACT N
1120 15TH ST., ALGUSTA 30902

FELOMAN, ELAINE B. 54 ACT I
MEO. COLLEGE OF GA., AUGUSTA 30902

FELKER, FORT F., JR. 76 ACT
216 N. PENTZ ST., OALTON 30720

FELLNER, OONALO W. 2S ACT OR
2788 BAYARO ST., EAST POINT 30344

FELNER, JOEL M. 2S A C
GRAOY MEM. HOSP., ATLANTA 30303

FERGUSON, IRA A., JR. 2S ACT SL
EMORY UNIV. CLINIC, ATLANTA 30322

FERGUSON, WILSON J. 2S ACT SL
GENERAL MOTORS CORP., OORAVILLE 30340

FERNANOEZ, ANDRES P. 16 ACT PATH
1660 BETHHAVEN RO., RIVEROALE 30274

FERNANDEZ, ANTONIO 6 ACT CR
870 HIGH ST., MACON 31201

FERNANDEZ, B. P. 42 S I
V. A. CENTER, OUBLIN 31021

FERNANOEZ, E. J. 7 ACT FP
SPRING ST., ELLIJAY 30540

FERNANOEZ, EZEQUIEL P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

FERNANCEZ, JOSE A. 65 ACT FP
2205 OLO MONTICELLO RD., THOMASVILLE 31792

FERRELL, M. LYNN 4S ACT FP
325 E. BROAO ST., SPARTA 31087

FERRELL, R. G., JR. 6 ACT SU
745 PINE STREET, MACON 31201

FERRELL, T. J., JR. 72 ACT I
1921 ALICE ST., WAYCROSS 31501

FERRELL, WM. C. 34 ACT R
HALL CO. HOSPITAL, GAINESVILLE 30501

FERRIER, FRANK L. 17 ACT TS
754 CHEROKEE, MARIETTA 30060

FERRIS, HAROLD A. 2S ACT I
478 PEACHTREE ST. N. E., ATLANTA 30308

FIEOOTIN, ARNOLDO 2S ACT I
265 IVY ST., N.E., ATLANTA 30303

FIELO, OAVIO E. 14 ACT FP
CANTON MEO. CTR., CANTON 30114

FILARDI, GERALO A. 22 ACT L
755 COLUMBIA CR., OECATUR 30030

FILLINGIM, OAVIO B. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401

FILLINGIM, OAVID W. 11 ACT CBG
1 ST. JOSEPH PROF. PLAZA, SAVANNAH 31406

FILLINGIM, JOHN M. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401

FILSON, EOGAR J. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405

FINCH, CHARLES S., JR. 2S ACT ANES
2550 WINDY HILL RO., MARIETTA 30061

FINCH, HENRY M. 2S ACT PR
490 PEACHTREE ST. N. E., ATLANTA 30308

FINCHER, RONALD E. 2S ACT CBG
35 COLLIER RD., N.W., ATLANTA 30309

FINCLAY, PRENTISS E. 23 ACT PD
412 FOURTH AVE., ALBANY 31705

FINE, ROBT. M. 22 ACT D
755 COLUMBIA CR., DECATUR 30030

FINEGAN, ROBERT FRANKLIN 2S ACT ANES
2760-B FELTON OR., EAST POINT 30344

FINGER, ELLIOTT R. 11 ACT PL
38 MEDICAL ARTS CENTER, SAVANNAH 31405

FINKLEA, JOHN L. 61 OE2 FP
NO CURRENT AOCRESS

FINNEY, C. E. 23 ACT CPH
521 THIRO AVE., ALBANY 31701

FINUCANE, BRENDAN T. 2S A ANES
69 BUTLER ST., OEPT. ANES., ATLANTA 30303

FISH, JOHN S. 2S ACT CB
340 BOULEVARO, N. E., ATLANTA 30312

FISHBACK, MALCOLM E. 54 ACT TS
1467 HARPER ST., AUGUSTA 30902

FISHBEIN, SUMNER 54 ACT CPH
1467 HARPER ST., AUGUSTA 30902

FISHER, GEORGE B. 6E ACT
FRANKLIN 30217

FISHER, J. EOWARO 2S ACT CBG
340 BOULEVARO, N. E., ATLANTA 30312

FISHER, WM. R. 2S ACT ALR
490 PEACHTREE ST., N. E., ATLANTA 30308

FISHMAN, LEONARO 22 ACT O
2754 N. DECATUR RO., OECATUR 30030

FITE, J. OONALO 22 ACT CPH
542 CHURCH ST., CECATUR 30030

FITZGERALO, EDMUNO M.,JR. 42 S I
VA CENTER, OUBLIN 31021

FITZHUGH, F. W., JR. 2S ACT I
1938 PEACHTREE ROAO, N. W., ATLANTA 30309

FITZPATRICK, PAUL E. 2S ACT I
6185 JONESBORO RD., MORROW 30260

FIVEASH, ARLIE E. 54 ACT R
1467 HARPER ST., AUGUSTA 30902

FIX, RICHARO M. 3C ACT PO
2705 WILOWOOO OR., BRUNSWICK 31520

FLANAGAN, JAMES C. 2S ACT P
3400 PEACHTREE RO., N. E., ATLANTA 30326

FLANAGAN, WM. C., JR. 47 ACT CBG
P.O. BOX 157, COLUMBUS 31902

FLANAGIN, W. STEWART 54 ACT PL
1125 CRUIO PARK AVE., AUGUSTA 30904

FLANOERS, CHARLES E., JR. 17 ACT ANES
754 CHEROKEE ST., N.E., MARIETTA 30060

FLEISHER, ALAN S. 2S ACT NS
80 BUTLER ST., SE, ATLANTA 30303

FLEMING, SIONEY F. 22 ACT P
1256 BRIARCLIFF RO., N. E., ATLANTA 30306

FLEMING, WILLIAM H. 2S ACT TS
1365 CLIFTON RO., N.E., ATLANTA 30322

FLESCH, W. L. 72 ACT L
BOX 1190, WAYCROSS 31501

FLETCHER, GERALD F. 29 A I
300 BOULEVARD, N. E., ATLANTA 30312

FLETCHER, MELVIN R. 17 ACT PD
122 CHERRY ST., MARIETTA 30060

FLINCHUM, DARIUS 29 ACT OR
340 BOULEVARD, N. E., ATLANTA 30312

FLINT, LUCIEN A. 14 ACT R
R. T. JONES MEM. HOSP., CANTON 30114

FLORENCE, LOREE 15 OE5 PD
P. O. BOX 682, ATHENS 30601

FLOURNOY, EDWIN E., JR. 23 ACT FP
1009 N. MONROE, ALBANY 31701

FLOURNOY, HENRY W. 30 ACT CBG
2444 PARKWOOD DR., BRUNSWICK 31520

FLOWERS, EUGENE MONROE 66 ACT FP
TIFTON 31794

FLOWERS, ROBERT M. 47 ACT PD
2039 WARM SPRINGS RD., COLUMBUS 31904

FLOWERS, THOMAS EDWARD 27 ACT CPH
103 JOHN MADDOX DR., ROME 30161

FLOYD, EARL H. 29 OE1 L
3705 VERMONT RD., N.E., ATLANTA 30319

FLOYD, T. J., JR. 59 ACT SL
506 S. 8TH ST., GRIFFIN 30223

FLOYD, WALDO E., JR. 6 ACT CR
870 HIGH ST., MACON 31208

FLYNN, GREGORY E. 29 ACT CPH
2550 WINDY HILL RD., UMC, MARIETTA 30062

FLYNN, JAMES T., JR. 19 ACT CALR
MOULTRIE 31768

FLYNN, THOMAS F. 60 OE4 SL
U. S. PHS. HOSP. 65DD, NORFOLK, VA. 23508

FOKES, ERNEST C. 22 ACT NS
365 WINN WAY, DECATUR 30030

FOKES, ROBERT E., JR. 19 ACT CALR
MOULTRIE 31768

FONTANA, NORVERTO A. 65 ACT FP
P. O. BOX 1867, THOMASVILLE 31792

FORBES, G. LESTER, JR. 29 ACT PATH
340 BOULEVARD, N.E., ATLANTA 30312

FORBIS, SAMUEL E., JR. 20 ACT R
P. O. BOX 997, NEWNAN 30263

FORD, HENRY J. 15 ACT P
1010 PRINCE AVE., ATHENS 30601

FORD, WILLIAM C. 28 ACT FP
BOX 5, LAVONIA 30553

FORESTER, B. W. 6 ACT I
724 HEMLOCK ST., MACON 31201

FORRESTER, EDWARD S., JR. 54 ACT CR
1515 POPE AVE., AUGUSTA 30904

FORSHNER, JOHN G. 76 ACT D
1217 MEMORIAL DR., DALTON 30720

FORSYTH, DOUGLAS H. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

FORTSON, LUTHER G., JR. 17 ACT I
KENNESTONE HOSP., MARIETTA 30060

FOSTER, CATHERINE E. 22 ACT OBG
924 W. SPRING ST., MONROE 30655

FOSTER, GURDON R., JR. 59 ACT FP
MCDONOUGH 30253

FOSTER, HENRY A. 59 ACT
319 S. 9TH ST., GRIFFIN 30223

FOSTER, H. R. 22 ACT PD
7660 COVINGTON HWY., LITHONIA 30058

FOSTER, THOMAS V. 47 ACT P
1953 SEVENTH AVE., COLUMBUS 31904

FOUNTAIN, T. GRAY 23 ACT SL
910 N. JEFFERSON, ALBANY 31705

FOWLER, C. DIXON 29 ACT PD
27 EIGHTH ST. N. E., ATLANTA 30309

FOWLER, JOHN E. 60 ACT FP
P. O. BOX 825, CLAYTON 30525

FOWLER, MAJOR F. 29 ACT L
2637 PEACHTREE RD., N.E., ATLANTA 30305

FOWLER, MARK W. 23 ACT FP
1010 N. MADISON ST., ALBANY 31701

FOWLER, R. W., JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060

FOX, BRENT 47 ACT CALR
MEDICAL ARTS BLDG., COLUMBUS 31901

FRANCH, ROBERT F. 29 ACT I
EMORY UNIV. CLINIC, ATLANTA 30322

FRANCK, GEORGE F. 29 ACT IND
64 PERIMETER CTR. EAST, N.E., ATL. 30346

FRANCO, JAIME 42 ACT PATH
LAURENS MEM. HOSP., DUBLIN 31021

FRANCO, NEO M. 29 ACT L
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

FRANCO, RICHARD C. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

FRANK, MARTIN J. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

FRANK, MILTON, III 29 ACT I
1175 PEACHTREE ST., N.E., ATLANTA 30309

FRANKLIN, ERNEST W. 29 ACT OBG
25 PRESCOTT ST., N.E., ATLANTA 30308

FRASER, WHITMAN 62 ACT FP
FRASER DRIVE, HINESVILLE 31313

FRAZIER, WESLEY T. 29 ACT ANES
1365 CLIFTON RD., N.E., ATLANTA 30322

FREANT, LAWRENCE J. 6 ACT C
726 FIRST ST., MACON 31201

FREDERICKSON, EVAN L. 29 ACT ANES
EMORY UNIV., ANES. DEPT., ATLANTA 30322

FREEMAN, L. M. 11 ACT SL
FREDERICK PL 105, 803 E 70TH, SAVANN 31405

FREEMAN, MILTON H. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312

FREEMAN, MURRAY A. 54 ACT CBG
1621 PENDLETON ROAD, AUGUSTA 30904

FREEMAN, SANDRA N. 54 ACT R
VA. HOSP., AUGUSTA 30904

FREEMAN, ATWOOD M., JR. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701

FREEMAN, CHARLES 54 ACT OR
1515 POPE AVE., AUGUSTA 30904

FREEMAN, JAMES C. 55 ACT FP
SYLVANIA 30467

FREEMAN, LAWRENCE C., JR. 29 ACT ANES
355 LINDBERG DR., N. E., ATLANTA 30305

FREEMAN, LAWRENCE L. 22 ACT
3652 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

FREEMAN, MALCOLM G. 29 A CBG
463 KIRK RD., DECATUR 30030

FREEMAN, OLEN I. 29 ACT P
5064 NANCINA LN., DUNWOODY 30338

FREEMAN, RONALD A. 6 ACT PL
380 HOSP. DR., MACON 31201

FREEMAN, THOMAS R. 11 ACT SL
200 EAST 31ST STREET, SAVANNAH 31401

FREGOSI, ALBERT H. 22 ACT U
755 COLUMBIA DR., DECATUR 30030

FRENCH, JAMES B. 34 ACT OBG
1100 VINE ST., GAINESVILLE 30501

FREYRE, ROBERT C. 48 ACT FP
943 COURT ST., CONYERS 30207

FRIEDEWALD, WM. F. 29 ACT I
1293 PEACHTREE ST., N.E., ATLANTA 30309

FRIEDRICH, ERIC W. 30 ACT OTC
2705 WILDWOOD DR., BRUNSWICK 31520

FRISTOE, JOHN W., JR. 22 ACT OBG
1551 MASON MILL RD., NE, ATLANTA 30329

FROLICH, DAVID J. 6 I&R
752 HEMLOCK ST., MACON 31201

FROST, H. R. 25 ACT
SWAINSBORO 30401

FUERST, JULIAN F. 22 ACT OBG
755 COLUMBIA DR., DECATUR 30030

FULGHUM, C. B. 2 ACT I
460 N. COLUMBIA ST., MILLEDGEVILLE 31061

FULGHUM, C. B., JR. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

FULGHUM, THOMAS F. 76 ACT I
HEALTH DEPT., DALTON 30720

FULLER, GEO. W. 29 OE5 FP
2638 PEACHTREE RD., N.E., ATLANTA 30305

FULLER, WM. A. 54 ACT I
1403 GWINNETT ST., AUGUSTA 30902

FULMER, THOMAS E. 29 ACT P
1711 AIDMORE DR., N.E., ATLANTA 30307

FULMER, WM. HENRY 11 ACT FP
22 E. 34TH ST., SAVANNAH 31401

FUNDERBURG, FREDERICK O. 2 OE5
6005 HUGHES ST., SAN DIEGO, CAL 92115

FUNDERBURKE, A. G. 19 OE1 FP
1935-4TH ST., SE, MOULTRIE 31768

FUNK, F. JAMES, JR. 29 ACT CR
1938 PEACHTREE ROAD, N. W., ATLANTA 30309

FUNK, SIDNEY A. 29 ACT OBG
275 CARPENTER DR., ATLANTA 30329

FUNKHOUSER, W. L. 29 OE5 PD
47 PEACHTREE PARK DR., N.E., ATLANTA 30309

FUSSELL, DANIEL O. 36 ACT I
212 HOSPITAL DR., WARNER ROBINS 31093

FUTCH, C. B. 30 ACT SL
2432 PARKWOOD DR., BRUNSWICK 31520

FUTCH, WILLIAM A. 48 ACT FP
CONYERS 30207

G

GABLE, THOMAS W. 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

GABLER, REGINA 29 ACT OBG
950 W. PEACHTREE ST. N. W., ATLANTA 30309

GAFFORD, A. V. 27 ACT CALR
HARBIN CLINIC, ROME 30161

GALAMBOS, JOHN T. 29 ACT I
69 BUTLER ST., S.W., ATLANTA 30303

GALEN, NORMAN R. 47 OE4 L
MARTIN ARMY HOSP., FT BENNING 31905

GALEN, WESLEY K. 47 ACT O
3816 CASPIAN DR., COLUMBUS 31901

GALIN, A. N. 30 DE1 FP
P.O. BOX 1055, ST. SIMONS IS. 31522

GALLEMORE, J. L. 6 ACT FP
PERRY 31069

GALLER, EDWIN J. 22 ACT I
2054-G LAWRENCEVILLE HWY, DECATUR 30033

GALLIS, ANTHONY H. 15 ACT I
1010 PRINCE AVE., ATHENS 30601

GALLASTRA, JUAN A. 17 ACT I
1039 RIDGE AVE., ATLANTA 30315

GALLOWAY, BENJAMIN THOMAS 30 ACT SL
3010 HAMPTON, BRUNSWICK 31520

GALLOWAY, GEORGE W., JR. 17 ACT FP
KENNESTONE HOSP., MARIETTA 30060

GALLOWAY, LOUISE J. 30 ACT ANES
2850 WILDWOOD DR., BRUNSWICK 31520

GALLOWAY, RONALD FROST 54 ACT TS
1467 HARPER ST., AUGUSTA 30902

GALLOWAY, WM. H. 29 ACT CBG
340 BOULEVARD, N. E., ATLANTA 30312

GALVIN, WM. H. 29 ACT ANES
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

GAMBRELL, W. ELIZABETH 29 OE5 I
384 PEACHTREE ST. N. E., ATLANTA 30308

GAMMAL, T. A. EL 54 ACT NR
MED. COLLEGE OF GA., AUGUSTA 30902

GAMWELL, JOHN W. 29 ACT OR
25 PRESCOTT ST., N.E., ATLANTA 30308

GANN, JOYCE A. 22 ACT CBG
365 WINN WAY, DECATUR 30030

GARCIA, BENITO 2 ACT FP
CENTRAL STATE HOSP. MILLEDGEVILLE 31061

GARCIA, J. BERNARDO 2 OE2 ANES
MED. COLLEGE OF GA., AUGUSTA 30902

GARCIA, P. F. 29 ACT P
3316 PIEDMONT RD, N.E., ATLANTA 30305

GARCIA, RUBEN E. 19 ACT FP
1010 PRINCE AVE., ATHENS 30601

GARDNER, JOSEPH M. 17 ACT CBG
2404 AUSTELL MARIETTA RD., AUSTELL 30001

GARDNER, NORMAN P. 69 ACT FP
101 AVENUE F, THOMASTON 30286

GARFIELD, HERBERT I. 16 ACT PD
217 ARROWHEAD BLVD., JONESBORO 30236

GARLAND, JOHN W., III 34 ACT P
500 E. SPRING ST., GAINESVILLE 30501

GARNER, CYLER D. 6 ACT
GORDON MEDICAL CENTER, GORDON 31031

GARNER, W. R. 34 DE5 I
RT. 12, BOX 163-1, GAINESVILLE 30501

GARRETT, LUKE G., JR. 17 ACT
AUSTELL 30001

GARRETT, ROBERT C. 26 ACT FP
412 CHURCH ST., VIENNA 31092

GARRISON, ALTON F. 54 ACT SL
808-13TH ST., AUGUSTA 30902

GARRISON, O. F. 33 DE5 FP
CLARKESVILLE 30523

GARRISON, FLETCHER O. 33 ACT FP
912 WAYSIDE ST., CORNELIA 30531

GARRISON, GLEN E. 54 ACT C
MED. COLLEGE OF GA., AUGUSTA 30902

GARRISON, JOSEPH MAYES 54 ACT ANES
812 13TH ST., AUGUSTA 30901

GATES, EDWARD M. 27 ACT NS
HARBIN CLINIC, ROME 30161

GATEWOOD, T. SCHLEY 61 ACT CBG
205 SOUTH LEE STREET, AMERICUS 31709

GAUTHIER, P. C. 6 ACT FP
JEFFERSONVILLE 31044

GAY, BRIT B., JR. 29 ACT R
1405 CLIFTON RD., N. E., ATLANTA 30333

GAY, FRANCIS M. 19 ACT FP
MOULTRIE 31768

GAY, THOMAS BOLLING 29 DE1 PD
3042 W. PINE VALLEY RD. N.W.,ATLANTA 30305

GECKLER, JOHN H. 29 ACT ANES
20 LINDEN AVE., N.E., ATLANTA 30308

GEDNEY, LEIGH M. 29 S L
B18, FED. ANNEX, ATLANTA 30304

GEE, W. N., JR. 56 ACT I
401 E. JANE ST., VALDOSTA 31601

GEER, BRUCE R. 29 ACT GE
3250 HOWELL MILL RD.,NW, STE 200, AT 30327

GEERKEN, LUIS A. 20 ACT ANES
COWETA GENERAL HOSPITAL, NEWNAN 30263

GEIGER, C. LEONARD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501

GENT, JACK 76 ACT SL
P. O. BOX 1069, DALTON 30720

GEORGE, WILLIAM M., JR. 23 ACT FP
907 JEFFERSON ST., ALBANY 31707

GERMAIN, A. H. 29 DE5 FP
259 ARROWHEAD BLVD., JONESBORO 30236

GERMAN, THOMAS L. 11 ACT CR
210 HALL ST. EAST, SAVANNAH 31401

GERSHON, NATHAN I. 29 ACT CALR
340 BOULEVARD, NE, ATLANTA 30312

GERSON, GORDON N. 17 ACT CR
1620 MULKEY RD., AUSTELL 30001

GERTLER, PHILLIP E. 29 ACT I
1938 PEACHTREE RD., N. W., ATLANTA 30309

GERTNER, HAROLD R., JR. 29 ACT SL
1968 PEACHTREE RD., N.W., ATLANTA 30309

GHANI, CHARLES A. 29 ACT ANES
1365 CLIFTON RD., N.E., ATLANTA 30322

GHENT, OLIVER T. 34 R R
HALL CO. HOSP., GAINESVILLE 30501

GHOLSON, A. R. 29 ACT ANES
180 LAUREL FOREST CIR., NE, ATLANTA 30305

GIBBS, R. I., JR. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033

GIBSON, FRANK L. 21 ACT SL
BAINBRIDGE 31717

GIBSON, HUGH F. 6 ACT CBG
380 HOSP. DR., MACON 31201

GIBSON, SAM T. 29 A
FDA, BLDG. 29, RM. 118, BETHESDA,MD. 20014

GIBSON, TIMOTHY B. 15 ACT FP
WINTERVILLE 30683

GIBSON, WALLACE M. 49 ACT
106 N. JEFFERSON ST., EATONTON 31024

GIDDENS, I. S. 56 ACT FP
LAKELAND 31635

GIDDENS, RICHARD O. 76 ACT SL
MEDICAL ARTS BLDG., DALTON 30720

GILBERT, BEN P. 34 ACT PD
650 BROAD ST., S.E., GAINESVILLE 30501

GILBERT, CARL N. 76 ACT PD
MEMORIAL DR., DALTON 30720

GILBERT, CHARLES A. 29 ACT I
69 BUTLER ST., S. E., ATLANTA 30303

GILBERT, CLYDE O. 60 ACT CBG
800 E. DOYLE ST., TOCCOA 30577

GILBERT, FREDERICK E. 20 ACT PATH
COWETA GENERAL HOSP., NEWNAN 30263

GILBERT, PETER G. 27 ACT L
HARBIN CLINIC, ROME 30161

GILBERT, WARREN 27 ACT FP
HARBIN CLINIC, ROME 30161

GILES, BEN J. 29 ACT ANES
384 PEACHTREE ST., N. E., ATLANTA 30308

GILES, EUGENE H. 5E ACT FP
322 S. MAIN ST., BLAKELY 31723

GILLESPIE, CHARLES B. 23 ACT CR
810 14TH AVE., ALBANY 31701

GILLESPIE, EUGENE J. 29 A D
47 TRINITY AVE., S. W., ATLANTA 30334

GILLESPIE, JOE I. 54 ACT ALR
1511 ANTHONY RD., AUGUSTA 30904

GILLESPIE, ROBERT H. 29 ACT CBG
1938 PEACHTREE RD., NW, ATLANTA 30309

GILLETT, BRUCE M. 17 ACT N
50 PLAZA WAY, MARIETTA 30060

GILLIAM, O. O. 47 OE5 SL
P. O. BOX 2016, COLUMBUS 31902

GILLIARD, FRED E. 1E ACT FP
WARD ST., DOUGLAS 31533

GILLIKIN, WILLIAM V., P.C 25 ACT FP
TWIN CITY 30471

GILMORE, THOMAS W., JR. 74 ACT I
P. O. BOX 190, SANDERSVILLE 31082

GILNER, DONALD M. 29 ACT AL
960 JOHNSON FERRY RD., ATL. 30342

GINOIN, R. ARTHUR 54 ACT NS
TALMADGE MEM. HOSP., AUGUSTA 30902

GINSBERG, STEWART T. 29 R P
960 JOHNSON FERRY RD., ATLANTA 30033

GIRARDEAU, HERBERT S., JR 22 ACT SL
1270 MCCONNELL DR., DECATUR 30033

GIRARDEAU, JOSEPH L. 29 ACT CBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

GLADSON, JAMES E. 29 ACT I
57 WILLOWICK CT., DECATUR 30034

GLASS, LAMAR F. 29 ACT SL
25 PRESCOTT ST., NW, STE. 4441, ATL 30308

GLASSMAN, ARMAND B. 54 ACT PATH
MED. COLLEGE OF GA., AUGUSTA 30902

GLENN, FRANK D. 11 I&R L
P.O. BOX 6688, SAVANNAH 31405

GLENN, T. LAMAR 15 ACT I
740 PRINCE AVE., ATHENS 30601

GLENN, WADLEY R. 29 ACT SL
35 LINDEN AVE. N. E., ATLANTA 30308

GLISSON, C. STEADMAN 29 ACT CBG
401 PEACHTREE ST., N.E., ATLANTA 30308

GLOVER, D. H. G. 54 ACT PH
1001 BAILIE ST., AUGUSTA 30902

GLOVER, DOUGLAS D. 17 ACT CBG
653 CHEROKEE ST., N.E., MARIETTA 30060

GLOVER, HOWARD C., JR. 20 ACT PD
NEWNAN 30263

GLOVER, N. B. 20 ACT PD
NEWNAN 30263

GLOVER, RIDLEY M. 42 ACT R
LAURENS MEM. HOSP., DUBLIN 31021

GLUCKSMAN, MICHEL A. 30 ACT L
2705 WILDWOOD DR., BRUNSWICK 31520

GODWIN, JOHN THOMAS 29 ACT PATH
265 IVY STREET, N. E., ATLANTA 30303

GOICOECHEA, PILAR 2 ACT R
P.O. BOX 507, HARDWICK 31034

GOLD, HOMER CECIL, JR. 14 ACT FP
200 MARIETTA ST., CANTON 30114

GOLD, PERRY 29 A PD
2795 MRGRT MITCHELL DR., N.W., ATL. 30327

GOLDEN, HOWARD A. 29 ACT CBG
970 HUNTER ST., S. W., ATLANTA 30314

GOLDENSTAR, G. W. 11 ACT CPH
26 MEDICAL ARTS CENTER, SAVANNAH 31405

GOLDIN, HAROLD W. 27 ACT FP
ROCKMART 30153

GOLDMAN, GILBERT C. 29 ACT O
5675 PTREE-DUNWOODY RD., N.E., ATL 30342

GOLDMAN, JOHN A. 29 ACT I
1365 CLIFTON RD., N.E., ATL. 30322

GOLDMAN, KENNETH L. 47 ACT SL
905 CENTER ST., COLUMBUS 31901

GOLDMAN, MILTON S. 29 ACT L
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

GOLDMAN, NORMAN I. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

GOLDSMITH, ABRAM D. 23 ACT CBG
P.O. BOX 714, ALBANY 31702

GOLDSMITH, HOWARD G. 47 ACT CR
2009 WARM SPRINGS RD., COLUMBUS 31901

GOLDSTEIN, MARTIN I. 17 ACT D
3001 S. COBB DR., S. E., SMYRNA 30080

GOLOWASSER, FRED E. 72 ACT FP
ALMA 31510

GOLSAN, WILLARD R. 6 OE5 L
417 AMERICAN FEDERAL BLDG., MACON 31201

GOMEZ, FRANK 29 ACT SL
ARROWHEAD MEDICAL PLAZA, JONESBORO 30236

GOMEZ, JULIAN R. 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

GOMEZ, MIGUEL R. 16 ACT ANES
33 SW UPPER RIVERDALE RD., RIVERDALE 30274

GOMEZ, ROBERT F. 15 ACT CTC
740 PRINCE AVE., ATHENS 30601

GONGAWARE, ROBERT D. 11 ACT SL
200 E. 31ST ST., SAVANNAH 31401

GONGAWARE, THEODORA L. 11 ACT I
P.O. BOX 6688, STAT C, SAVANNAH 31405

GONZALEZ, FRANCISCO E. 14 ACT CBG
CANTON MEDICAL CENTER, CANTON 30114

GONZALEZ, JOSE M. 2 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31062

GONZALEZ, PABLO E. 29 ACT
4508 CHERIE GLEN TRAIL, ST. MT., 30083

GONZALEZ, VICTOR R. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATL 30329

GOODRICH, SAMUEL M. 2 ACT CBG
P.O. BOX 489, MILLEDGEVILLE 31061

GOODWIN, BURTON D., JR. 11 ACT R
P. O. BOX 6688, SAVANNAH 31401

GOODWIN, FRANKLIN H. 42 S I
V A CENTER, DUBLIN 31021

GOODWIN, H. A., JR. 27 ACT FP
SUMMERVILLE 30747

GOODWIN, HENRY N. 54 ACT OR
1521 ANTHONY RD., AUGUSTA 30904

GOODWIN, T. W. 54 DE1 SU
1 INDIAN COVE, AUGUSTA 30904

GOODWYN, THOS. P. 29 DE5 OR
2840 WOODWARD WAY, N.W., ATLANTA 30305

GOOLSBY, SARA L. 70 ACT
211 ANDREWS ST., ROSSVILLE 30741

GORDON, JAMES H. 57 S PH
TOOMBS COUNTY HEALTH DEPT., LYONS 30436

GORDON, STEPHEN F. 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

GORDON, WALTER C. 23 ACT SU
413 S. MADISON ST., ALBANY 31701

GOSS, CHRISTOPHER C. 26 ACT FP
ASHBURN 31714

GOSS, WOODROW 26 ACT FP
ASHBURN 31714

GOTTSCHALK, ROBERT BRUCE 11 ACT SL
1 MEDICAL ARTS CENTER, SAVANNAH 31405

GOULD, MARK A. 17 ACT P
3188 ATLANTA ROAD, SMYRNA 30080

GOWDER, GEORGE O., JR. 34 ACT
P. O. BOX 726, BLAIRSVILLE 30512

GOWEN, JAMES F. 3C ACT CBG
2444 PARKWOOD DR., BRUNSWICK 31520

GOWER, ORIEN T., JR. 26 ACT FP
CORDELE 31015

GOWER, W. J. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286

GRABLOWSKY, OSCAR M. 29 ACT SL
340 BOULEVARD, N.E., ATLANTA 30312

GRACE, KENNETH O. 68 ACT SL
206 CHURCH ST., LAGRANGE 30240

GRACIAA, GUIOD F. 2 ACT N
CENTRAL STATE HOSP., MILLEDGEVILLE 31061

GRADY, CHARLOTTE 29 A
35 LINDEN AVE., N.E., ATLANTA 30308

GRADY, DONALD F. 29 ACT NS
1175 PEACHTREE ST., N. E., ATLANTA 30309

GRADY, EDGAR O. 29 ACT
2788 BAYARD ST., EAST POINT 30344

GRAFFAGNINO, P. C. 47 ACT CBG
MEDICAL ARTS BLDG., COLUMBUS 31901

GRAHAM, HAMLIN 54 ACT CR
1021 15TH ST., AUGUSTA 30901

GRAHAM, THOMAS C. 2C ACT CBG
P. O. BOX 609, NEWNAN 30263

GRAHAM, WILLIAM L. 47 ACT R
P. O. BOX 2787, COLUMBUS 31901

GRAHAM, WISTAR L. 17 ACT NS
86 S. COBB DR., MARIETTA 30060

GRAMLING, Z. W. 54 ACT ANES
TALMADGE MEM. HOSP., AUGUSTA 30902

GRANT, EDWIN H. 1C ACT R
TANNER MEMORIAL HOSP., CARROLLTON 30117

GRANT, JOHN R. 23 ACT OTC
804 14TH AVE., ALBANY 31705

GRANT, R. PERRY 22 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

GRANT, ROBERT 34 ACT CBG
174 PINE ST. SE, GAINESVILLE 30501

GRANTHAM, C. C. 6 ACT ANES
P. O. BOX 352, GRAY 31032

GRANTHAM, V. J. 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030

GRANTIER, DAVID R. 17 ACT FP
COBB GENERAL HOSP., AUSTELL 30001

GRAVANIS, MICHAEL B. 29 ACT PATH
1365 CLIFTON RD., N. E., ATLANTA 30322

GRAVES, EDWARD M. 6C ACT
MEDICAL ARTS BLDG., TOCCOA 30577

GRAVES, RAPHAEL K. 29 ACT PATH
1000 JOHNSON FERRY RD., N.E., ATL. 30345

GRAY, ARTHUR R. 27 ACT SL
310 W. SIXTH ST., ROME 30161

GRAY, DALE A. 36 ACT FP
6520 NORTHLAND AVE., ALBUQUERQUE, NM 87111

GRAY, J. O. 54 DE5 I
J. DEWEY GRAY CIRCLE, AUGUSTA 30904

GRAY, JAMES R. 22 A PD
69 BUTLER ST., S.E., ATLANTA 30303

GRAY, SAMUEL H. 22 ACT SL
4556 N. SHALLOWFORD RD., ATLANTA 30341

GRAYDON, E. LEONARD 29 DE5 FP
101 3RD ST., N.E., ATLANTA 30308

GRAYSON, JOHN T. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223

GREEN, ALFRED JOSEPH 54 ACT PD
1727 CENTRAL AVENUE, AUGUSTA 30904

GREEN, CHARLES G. 9 ACT FP
223 EAST 6TH ST., WAYNESBORO 30830

GREEN, DONARELL R., JR. 15 A FP
MORTON BLDG., ATHENS 30601

GREEN, EDMOND W. 29 ACT FP
3395 STEWART AVE., HAPEVILLE 30354

GREEN, GEORGE F. 49 ACT FP
325 E. BROAD ST., SPARTA 31087

GREEN, JAMES A. 15 ACT SL
1010 PRINCE AVE., ATHENS 30601

GREEN, JAMES FRANKLIN 1C ACT FP
POWELL CLINIC, VILLA RICA 30180

GREEN, RICHARD L. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30060

GREENBERG, IRVING L. 29 ACT SL
950 W. PEACHTREE ST. N. W., ATLANTA 30309

GREENBERG, JOEL I. 29 ACT OBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

GREENBLATT, ROBERT B. 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

GREENWALD, HERBERT S., JR 6 ACT CPH
380 HOSPITAL DR., MACON 31201

GREER, CHARLES C. 26 ACT CPH
BOX 1145, CORDELE 31015

GREER, MACK V. 56 ACT FP
P. O. BOX 146, HOMERVILLE 31634

GREGOROFF, STANLEY 29 ACT I
384 PEACHTREE ST., N.E., ATLANTA 30308

GREGORY, HUGH H. 29 ACT SL
735 PIEDMONT AVE., N.E., ATLANTA 30308

GREGORY, JAMES R. 76 ACT CBG
1217 MEMORIAL DR., DALTON 30720

GRESHAM, WALTER S. 1C ACT
BOWDEN 30108

GRIFFETH, JOE L. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529

GRIFFIN, BASIL M., JR. 29 ACT CR
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

GRIFFIN, JACK T. 47 ACT NS
2009 WARM SPRINGS RD., COLUMBUS 31904

GRIFFIN, JOHN B., JR. 22 ACT P
1365 CLIFTON RD., N. E., ATLANTA 30322

GRIFFIN, JOHN M. 29 ACT PI
3250 HOWELL MILL RD., N.E., ATLANTA 30327

GRIFFIN, LOUIE H., JR. 54 ACT SL
1430 HARPER ST., AUGUSTA 30902

GRIFFIN, RICHARD A., III 4 ACT SL
P. O. BOX 764, CARTERSVILLE 30120

GRIFFIN, WARREN L., JR. 6 ACT CTC
800 FIRST ST., MACON 31201

GRIFFITH, THOMAS H. 17 ACT G
652 CHURCH ST., MARIETTA 30060

GRIMES, W. H., JR. 29 ACT CB
340 BOULEVARD, N. E., ATLANTA 30312

GRINER, WALLACE 47 ACT
5740 WILTSHIRE DR., COLUMBUS 31907

GRISAMORE, J. M. 29 ACT SL
6500 VERNON WOODS RD., N.E., ATLANTA 30328

GROSS, PETER R. 29 ACT I
384 PEACHTREE ST., N. E., ATLANTA 30308

GROSSMAN, CONRAD P. 6 ACT CBG
380 HOSP. DR., MACON 31201

GROSSMAN, GILBERT O. 29 ACT I
25 PRESCOTT ST., N.E., ATLANTA 30308

GROVES, ROBERT H. 23 ACT FP
1100 N. MADISON ST., ALBANY 31701

GRUSH, OWEN C. 29 ACT PD
69 BUTLER ST., S. E., ATLANTA 30303

GUDE, A. V. 29 ACT ANES
3464 PINESTREAM RD., N.W., ATLANTA 30327

GUERNICA, EDUARDO 2 ACT P
STATE HOSP., MILLEDGEVILLE 31062

GUERRY, RODERICK L. 11 ACT PATH
P. O. BOX 9787, CANDLER HOSP., SAV 31402

GUFFIN, THOMAS N. 29 ACT SU
461 KING ARNOLD ST., HAPEVILLE 30054

GUILLEBEAU, F. DEMPSEY 23 ACT I
P. O. BOX 288, ALBANY 31702

GULLEN, WARREN H. 54 ACT E
MED. COLLEGE OF GA., AUGUSTA 30902

GUNTER, OLIVER L. 46 ACT FP
34 PERRY ST., CAMILLA 31730

GUSSACK, HAROLD A. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308

GUY, J. CANDLER 29 ACT L
3312 PIEDMONT RD., N. E., ATLANTA 30305

H

HAAK, EDWARD DECKER 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

HAAR, FLOYD L. 54 ACT NS
TALMADGE MEM. HOSP., AUGUSTA 30904

HAAS, MELVIN L. 54 ACT N
1003 CHAFEE AVE., AUGUSTA 30904

HABERMAN, GEORGE G. 11 ACT SL
P. O. BOX 9787, SAVANNAH 31402

HACKER, MORTIMER 29 ACT PATH
1330 W. PTREE ST., N.W., ATLANTA 30309

HACKNEY, J. F. 29 DE1 PH
1611 MILL ACRES DR., S.W., ATLANTA 30311

HADAWAY, PHIL L. 11 ACT FP
716 E. 71ST ST., SAVANNAH 31405

HADDAD, LESTER M. 11 ACT EM
P. O. BOX 6688, STE. C, SAVANNAH 31405

HADLEY, ELIZABETH 16 ACT R
33 UPPER RIVERDALE RD., STE 105, RIV 30274

HAGAN, JOHN C., III 29 A CPH
80 BUTLER ST., SE, ATLANTA 30303

HAGEN, ARTHUR R. 3C ACT OR
3010 HAMPTON AVE., BRUNSWICK 31522

HAGLER, JAMES R. 47 ACT FP
NO CURRENT ADDRESS

HAGLER, WILLIAM S. 29 ACT CPH
575 W. PEACHTREE ST., N. E., ATLANTA 30308

HAGOOD, MURL F. 17 ACT SL
660 CHEROKEE ST., MARIETTA 30060

HAGOOD, M. M. 17 ACT SL
50 PLAZA WAY, MARIETTA 30060

HAGOOD, RICHARD M. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001

HAHN, EDWARD E. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406

HAILEY, CHENAULT W. 29 ACT O
478 PEACHTREE ST., N. E., ATLANTA 30308

HAJOSY, ELAINE L. 27 ACT ANES
P. O. BOX 27, ROME 30161

HAJOSY, LOUIS S., JR. 27 ACT ANES
FLOYD HOSPITAL, ROME 30161

HAJOSY, RALPH W. 59 ACT CR
815 S. 8TH ST., GRIFFIN 30223

HALL, GEORGE W. 17 ACT R
3950 AUSTELL RD., AUSTELL 30001

HALL, HENRY L. 29 ACT P
EMORY UNIVERSITY, ATLANTA 30322

HALL, JESSE DENNY, JR. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223

HALL, JOHN C. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

HALL, JOHN I. 6 DE5 CR
P. O. BOX 6000, MACON 31208

HALL, MAXWELL F., JR. 17 ACT R
70 TOWER RD., MARIETTA 30060

HALL, THOMAS M., II 6 ACT P
2437 VINEVILLE AVE., MACON 31204

HALL, W. D. 31 ACT SL
CALHOUN 30701

HALLMAN, B. L. 29 ACT I
80 BUTLER ST., S.E., ATLANTA 30303

HALLMAN, HELEN W. 29 ACT ANES
159 FORREST AVE., N.E., ATLANTA 30303

HALLUM, ALTON V. 29 DE5 CPH
3280 HOWELL MILL RD., N.W., 207 ATL 30327

HALLUM, ALTON V., JR. 29 ACT CBG
35 COLLIER RD., N.W., ATLANTA 30309

HALTIWANGER, EARL 29 S L
1670 CLAIRMONT RD., N. E., ATLANTA 30329

HAM, OSCAR EMERSON 11 ACT PD
835 E. 65TH ST., SAVANNAH 31405

HAMES, CURTIS G. 6 ACT I
CLAXTON 30417

HAMFF, LEONARD H. 29 ACT I
478 PEACHTREE ST. N. E., ATLANTA 30308

HAMILTON, NEWELL M. 30 ACT PD
2001 GLOUCESTER ST., BRUNSWICK 31520

HAMILTON, SANDRA D. 15 ACT ANES
165 DUNWOODY DR., ATHENS 30601

HAMILTON, THOMAS E. 13 ACT FP
1106 DULUTH HWY., N.W.,LAWRENCEVILLE 30245

HAMILTON, VIRGINIA D. 4 A PH
P. O. BOX 1029, ROME 30161

HAMILTON, WALTON W. 42 S R
2333 KINGS WAY, AUGUSTA 30904

HAMM, WM. G. 29 DE5 PL
1938 PEACHTREE RD., N.W., ATLANTA 30309

HAMMETT, F. HILT, JR. 6E ACT CALR
HAMMETT BLDG., LAGRANGE 30240

HAMMONDS, RICHARD LEE 17 ACT FP
AUSTELL 30001

HAMMONDS, WILLIAM D. 29 ACT ANES
1365 CLIFTON RD., NE, ATLANTA 30322

HANBERRY, RICHARD L. 6 ACT CBG
657 HEMLOCK STREET, MACON 31201

HANCOCK, CARL V., JR. 23 ACT L
810-13TH AVE., ALBANY 31701

HANCOCK, CHARLES I. 29 ACT CR
340 BOULEVARD, N.E., ATLANTA 30312

HANCOCK, ROBERT K. 29 ACT CBG
490 PEACHTREE ST., N.E., ATLANTA 30308

HANCOCK, S. L. 65 DE1
2ND AVE., S. E., CAIRD 31728

HANDY, JOHN R. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904

HANES, D. EUGENE 29 ACT I
600 W. PEACHTREE ST. N. E., ATLANTA 30308

HANKEY, DANIEL D. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308

HANKS, JACK B. 12 ACT FP
33 CHESTNUT STREET, ELBERTON 30635

HANNA, MICHAEL B. 20 ACT OPH
85 ACKSON ST., NEWNAN 30263

HANNAH, JAMES F. 15 ACT EM
435 PONDEROSA DR., ATHENS 30601

HANNER, JAMES P. 29 DE5 PD
49-26TH ST., N. E., ATLANTA 30309

HANSEN, RICHARD A. 70 ACT FP
WILDWOOD HOSP., WILDWOOD 30757

HANSEN, ROBERT F. 29 S
2 EMMA LN., N.E., ATLANTA 30305

HANSON, I. R., JR. 17 A R
3865 STORY DR., MARIETTA 30060

HANSON, J. FLETCHER 6 DE5 I
3834 THE PRADO, MACON 31204

HARASZTI, ALEXANDER 29 ACT SL
217 ARROWHEAD BLVD., JONESBORO 30236

HARASZTI, ROSALIE 29 ACT FP
217 ARROWHEAD BLVD., JONESBORO 30236

HARBIN, BANNESTER L., JR. 27 ACT SL
HARBIN CLINIC, ROME 30161

HARBIN, LESTER 27 ACT SL
HARBIN CLINIC, ROME 30161

HARBIN, R. M., JR. 27 DE5 SL
19 HORSELEG CREEK RD., ROME 30161

HARBIN, THOMAS S. 27 ACT CPH
HARBIN CLINIC, ROME 30161

HARBIN, W. P., JR. 27 ACT I
HARBIN CLINIC, ROME 30161

HARBOUR, JOHN F. 17 ACT I
P. O. BOX 1266, SMYRNA 30080

HARDCASTLE, WILLIAM R. 22 ACT SL
9 LAVISTA PERIMETER DEC. PK., TUCKER 30084

HARDEN, CLIFFORD B. 36 ACT P
212 HOSPITAL DRIVE, WARNER ROBINS 31093

HARDEN, TIMOTHY, JR. 22 ACT I
711 CHURCH STREET, DECATUR 30030

HARDEN, W. E. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

HARDIN, FREDERICK F. 29 ACT D
1938 PEACHTREE RD., N. W., ATLANTA 30309

HARDMAN, BILLY S. 34 ACT CBG
420 BROAD ST., GAINESVILLE 30501

HARDMAN, WILLIAM J. 15 ACT CBG
740 PRINCE AVE., ATHENS 30601

HARDY, WALLACE E. 22 ACT CBG
5 LAVISTA PERIMETER PARK, TUCKER 30084

HARLEY, EUGENE L. 17 ACT I
705 CONCORD RD., SMYRNA 30080

HARLIN, JOYCE A. 29 A R
80 BUTLER ST., S. E., ATLANTA 30303

HARPER, BYRON F., JR. 29 ACT I
2741 BAYARD ST., EAST POINT 30344

HARPER, CHARLES R. 29 ACT AM
P. O. BOX 20767, ATLANTA 30320

GREENE, RALPH R. 70 ACT FP
P. O. BOX 460, RINGGOLD 30736

HARPER, HARRY T., JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

HARPER, HARRY T., III 54 ACT C
1467 HARPER ST., AUGUSTA 30902

HARPER, HENRY W., JR. 6 ACT ANES
742 CAPTAIN KELL DR., MACON 31204

HARPER, HERBERT S. 54 ACT PD
996 CAMPBELLTN RD., N. AUGUSTA, S. C. 29841

HARPER, WILLIAM FERRELL 23 ACT SL
810-13TH AVE., ALBANY 31701

HARPER, WILLIAM N. 29 ACT FP
75 PIEDMONT AVE., N.E., ATLANTA 30303

HARRELL, E. L. 75 ACT
RT. 4, BOX 424, JESUP 31545

HARRELL, H. P. 54 DE1 PD
1011 MARSHALL AVE., N. AUGUSTA, SC 29841

HARRIS, BOAZ 29 ACT P
490 PEACHTREE STREET, NE, ATLANTA 30308

HARRIS, GILBERT D. 15 ACT FP
850 GAINES SCHOOL RD., ATHENS 30601

HARRIS, J. FRANK 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308

HARRIS, JAMES B. 29 ACT CBG
1478 MOZLEY DR., S.W., ATLANTA 30314

HARRIS, J. HENRY WALKER 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

HARRIS, JOHN A. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

HARRIS, MICHAEL N. 29 ACT FP
400 COLONY SQ. #1505, ATLANTA 30361

HARRIS, STERLING A. 13 ACT
DOCTORS BUILDING, BUFORD 30518

HARRIS, T. A. 29 ACT OBG
340 BOULEVARD, N. E., ATLANTA 30312

HARRIS, WESLEY W. 28 ACT FP
ROYSTON 30662

HARRISON, CHARLES E., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

HARRISON, CLYCE C., JR. 16 ACT
1019 ASTOR AVE., FOREST PARK 30050

HARRISON, EUGENE D. 29 ACT SL
340 BOULEVARD, N. E., ATLANTA 30312

HARRISON, F. N. 54 ACT OBG
1021 15TH ST., AUGUSTA 30901

HARRISON, GEORGE I. 17 ACT ALR
1416 CHEROKEE ST., MARIETTA 30062

HARRISON, JAMES HAROLD 29 ACT
490 PEACHTREE ST. N. E., ATLANTA 30308

HARRISON, JOHN R. 22 ACT
5372 PEACHTREE RD., CHAMBLEE 30341

HARRISON, WALTER E. 19 ACT FP
711 S. MAIN, MOULTRIE 31768

HARTLAGE, PATRICIA L. 54 ACT CR
MED. COLLEGE OF GA., AUGUSTA 30902

HARTLEY, JOHN H., JR. 29 ACT PL
1938 PEACHTREE RD., N. W., ATLANTA 30309

HARTLEY, S. T. 16 ACT EM
4614 WINTHROP DR., COLLEGE PK. 30337

HARTMANN, HARRY R. 11 ACT R
P. O. BOX 6686, SAVANNAH 31405

HARTRAMPF, CARL R. 29 ACT PL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

HARVEY, DAVID N., III 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093

HARVEY, LOUIS R. 19 A PH
P. O. BOX 383, SANDERSVILLE 31082

HARWELL, C. W. 19 A PH
561 CANDLEWOOD DR., ST. MOUNTAIN 30083

HASTINGS, E. V. 54 ACT PATH
ST. JOSEPHS HOSPITAL, AUGUSTA 30904

HASTON, HUGH B., JR. 15 ACT CR
125 KING AVE., ATHENS 30601

HASTY, LEWIS B. 29 ACT CBG
1702 CLEVELAND AVE., EAST POINT 30344

HATCH, JOSEPH C. 56 ACT SL
ADEL 31620

HATCHER, CHARLES R. 29 ACT TS
EMORY CLINIC, ATLANTA 30322

HATCHER, MILFORD B. 6 ACT SU
781 SPRING ST., MACON 31201

HATFIELD, HUGH A. 22 ACT FP
2064 PATREE INDUSTRIAL CT., CHAMBLEE 30341

HATHCOCK, WM. C. 29 ACT CALR
401 PEACHTREE ST., N.E., ATLANTA 30308

HATTAWAY, JAMES R. 23 ACT U
810-13TH AVE., ALBANY 31701

HAUCK, A. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308

HAUGEN, HARRY T. 29 ACT FP
2391 SEWELL RD., S.W., ATLANTA 30311

HAUN, OSMO L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322

HAVERTY, JOHN RHODES 29 ACT PD
UNIVERSITY PLAZA, ATLANTA 30303

HAWK, JUDSON LOUIS, JR. 29 ACT PD
3162 PIEDMONT RD., N. E. ATLANTA 30305

HAWKINS, KATRINE RAWLS 55 ACT FP
P. O. BOX 518, SYLVANIA 30467

HAY, S. H. 60 ACT I
TOCCOA 30577

HAYES, THOMAS E. 70 ACT SL
711 MEDICAL ARTS, CHATTANOOGA, TN. 37404

HAYES, WILLIAM H. 47 ACT PATH
P. O. BOX 4176, COLUMBUS 31904

HAYMORE, JAMES M. 7 ACT FP
BOX 578, BLUE RIDGE 30513

HAZELHURST, W. CERREL 6 ACT I
765 SPRING ST., MACON 31201

HAZOURI, LOUIS A. 47 ACT NS
P. O. BOX 5306, COLUMBUS 31906

HEAD, O. L., JR. 69 ACT FP
E. THOMPSON ST., THOMASTON 30286

HEADLEY, WM. MCKENOREE 2 ACT SU
811 N. COBB ST., MILLEDGEVILLE 31061

HEARD, JOHN P. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030

HEARIN, DAVID L. 29 ACT O
3158 MAPLE DR. N. E., ATLANTA 30305

HEATH, GEORGE S. 72 ACT FP
P. O. BOX 1131, WAYCROSS 31501

HEATH, HEZEKIAH K., JR. 72 ACT
P. O. BOX 1131, WAYCROSS 31501

HEATON, SAMUEL A., JR. 34 A FP
LAURENS CO. HEALTH DEPT., DUBLIN 31021

HECHT, HOWARD L. 29 ACT DR
6500 VERNON WOODS DR., O-22, AT 30328

HEFFERNAN, J. ANTHONY, JR 11 ACT FP
20 MEDICAL ARTS CENTER, SAVANNAH 31405

HEILMAN, RICHARD B. 29 ACT INO
BOX 13083, ATLANTA 30310

HEIN, DAVID E. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312

HELLENGA, IRVING D. 60 ACT FP
TOCCOA CLINIC, TOCCOA 30577

HELTON, B. L. 74 OE5 FP
524 WASHINGTON AVE., SANDERSVILLE 31082

HELTON, WILLIAM S. 74 ACT FP
522 WASHINGTON AVE., SANDERSVILLE 31082

HENDEE, ARMAND ELKIN 29 ACT GBG
EMORY UNIVERSITY CLINIC, ATLANTA 30322

HENDERSON, CHARLES T. 17 ACT SU
521 CAMPBELL HILL ST., MARIETTA 30060

HENDERSON, WARREN S. P. 2 ACT SU
CENTRAL STATE HOSP., MILLEDGEVILLE 31061

HENDLEY, JOHN ELL 8 ACT FP
101 E. COLLEGE AVE., MILLEN 30442

HENDRICK, A. G. 36 ACT FP
1100 SWIFT ST., PERRY 31069

HENDRICKS, CHAS M., JR. 42 S I
V A CENTER, DUBLIN 31021

HENDRICKS, WILLIS M. 6E ACT GBG
LAGRANGE 30240

HENDRIX, ARTHUR M. 14 ACT FP
CANTON 30114

HENDRIX, VERNON J. 29 ACT GBG
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

HENDRY, CHARLES H. 16 ACT P
33 SW UPPER RIVERDALE RD., RIVERDALE 30274

HENDRY, KATHERINE MCM. 72 ACT FP
BLACKSHEAR 31516

HENDRY, WM. A. 72 OE1 FP
BLACKSHEAR 31516

HENRY, GEORGE T. 59 ACT FP
BARNESVILLE 30204

HENRY, J. LAMONT 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

HENSLEY, E. A. 54 OE1
GIBSON 30810

HENSLEY, E. R. 9 ACT
CORNER CHURCH & COUNCIL, WAYNESBORO 30830

HENSON, PAUL E., JR. 76 ACT U
BROADRICK DR., DALTON 30720

HERNANDEZ, FERNANDO G. 36 ACT I
212 HOSPITAL DR., WARNER ROBINS 31093

HERNANDEZ, JULIO 1 ACT FP
301 W. PARKER, BAXLEY 31513

HERNANDEZ, R. J. 29 ACT ANES
384 PEACHTREE ST., N. E., ATLANTA 30308

HERNDON, EUCLID G., JR. 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322

HERNDON, JOHN W. 18 ACT FP
OCILLA RD., DOUGLAS 31533

HERRIN, E. V. 15 ACT CBG
740 PRINCE AVE., ATHENS 30601

HERRING, JOHN S., JR. 6 ACT GBG
675 NEW ST., MACON 31201

HERRON, JAMES G. 61 ACT I
1102 E. LAMAR AVE., AMERICUS 31709

HERSH, THEODORE 29 ACT GE
1365 CLIFTON RD., N. E., ATLANTA 30322

HERTELL, JOSEPH A. 29 ACT I
3001 N. FULTON DR., N.E., ATLANTA 30305

HESTER, THOMAS R., JR. 19 ACT SU
S. MAIN ST., MOULTRIE 31768

HETHERINGTON, THOMAS A. 11 ACT R
311 E. HALL ST., SAVANNAH 31401

HEWELL, GUY C. 29 DE5 GBG
1123 BERKSHIRE RD., N.E., ATLANTA 30309

HICKS, JAMES M. 30 ACT GALR
1005 LANIER BLVD., BRUNSWICK 31520

HICKS, L. G., JR. 33 ACT ANES
CLARKESVILLE 30523

HIERN, BARRIE C. 27 ACT ANES
122 SADDLE MOUNTAIN RD., ROME 30161

HIGGINS, ALEXIS C. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

HIGHTOWER, JOHN A. 30 ACT I
4101 RIVERSIDE DR., BRUNSWICK 31520

HIGHTOWER, SAMUEL J. 6 ACT NS
740 HEMLOCK ST., MACON 31201

HILL, JOHN B. 15 ACT CBG
740 PRINCE AVENUE, ATHENS 30601

HILL, JULIUS N., III 29 ACT ANES
384 PEACHTREE ST., N.E., ATLANTA 30308

HILL, WM. H. 29 ACT SU
710 PEACHTREE ST. N. E., ATLANTA 30308

HILLIS, CHARLES L. 29 ACT FP
P. O. BOX 846, LAFAYETTE 30728

HILSMAN, A. H., III 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

HILSMAN, J. H. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

HILSMAN, P. L. 23 ACT GBG
1599 MEMORIAL DR., S. E., ATLANTA 30317

HILTY, MILO O. 54 ACT PO
561 S. 17TH ST., COLUMBUS, OHIO 43205

HINES, ROBERT C. 27 ACT FP
HARBIN CLINIC, ROME 30161

HINTON, GOLDEN S. 15 ACT CPH
220 N. MILLEDGE AVE., ATHENS 30601

HIRSCH, JACK 47 ACT I
909 CENTER ST., COLUMBUS 31901

HIRT, ALFREDO 29 ACT L
490 PEACHTREE ST., N. E., ATLANTA 30308

HITT, WILLIAM A. 75 ACT FP
P. O. BOX 604, JESUP 31545

HIXSON, GORDON L. 70 ACT R
TRI COUNTY HOSPITAL, FT. OGLETHORPE 30742

HLEAP, DAVID 29 ACT FP
4555 N. SHALLOWFORD RD., ATLANTA 30342

HOBBY, A. WORTH 29 DE5 PUL
490 PEACHTREE ST., N.E., ATLANTA 30308

HOBBY, CHARLES F. 56 ACT R
104 DOCTORS BLDG., VALDOSTA 31603

HOBBY, LOVIC W. 29 ACT SU
35 COLLIER RD., N.W., ATLANTA 30309

HOBSON, JOHN L. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

HOCKENHULL, JOHN A. 29 ACT FP
P. O. BOX 188, NICHOLLS 31554

HODGES, C. HUBERT, JR. 69 ACT U
808 GORDON AVE., THOMASVILLE 31792

HODGES, CHAS. A., JR. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31601

HODGES, HUGH O. 3 ACT FP
703 E. BROAD ST., WINDER 30680

HODGES, JOHN M. 17 ACT SU
805 CAMPBELL ST., MARIETTA 30062

HODGES, MALCOLM R. 6 ACT FP
1221 NEWBURG AVE., MACON 31206

HODGES, THOMAS L. 33 ACT I
WILDWOOD CIRCLE, CLARKESVILLE 30523

HOFFMAN, BYRON J. 29 ACT I
768 JUNIPER ST. N. E., ATLANTA 30308

HOFFMAN, FRANK 11 ACT ALR
24 MEDICAL ARTS CENTER, SAVANNAH 31405

HOFFMAN, JAMES C., JR. 29 ACT R
1365 CLIFTON RD., N. E., ATLANTA 30322

HOFFMAN, KATHRYN A. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

HOGAN, J. T., JR. 6 ACT FP
781 SPRING ST., MACON 31201

HOGSETTE, GERALD B. 55 ACT SU
SYLVANIA 30467

HOGUE, WILLIAM L. 54 ACT R
TALMADGE HOSP., AUGUSTA 30904

HOLBROOK, WILLIAM H., JR. 15 ACT FP
797 COBB ST., ATHENS G. HOS., ATHENS 30601

HOLDEN, WILLIAM H. 6 DE5 ALR
% H.S. COLBATH, 380 RVDL. RD., MACON 31204

HOLDER, F. P., JR. 50 ACT SU
P. O. BOX 569, EASTMAN 31023

HOLDER, J. S. 68 ACT SU
LAGRANGE 30240

HOLLADAY, WM. EDWARD, JR. 17 ACT
787 CAMPBELL HILL ST., MARIETTA 30062

HOLLAND, BERNARD C. 29 ACT P
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

HOLLEY, JACOB H. 21 ACT FP
DONALSONVILLE 31745

HOLLIS, CHARLES D., JR. 23 ACT I
P. O. BOX 288, ALBANY 31702

HOLLOMAN, J. J. 11 ACT FP
313 E. HALL STREET, SAVANNAH 31401

HOLLOWAY, ALFRED M. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286

HOLLOWAY, CHAS. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308

HOLLOWAY, EMORY W., JR. 37 A FP
P. O. BOX 126, COMMERCE 30529

HOLLOWAY, GEORGE A. 29 ACT GBG
35 COLLIER RD., N.W., ATLANTA 30309

HOLLOWAY, WILMER O. 6 ACT
P. O. BOX 388, TIFTON 31794

HOLMAN, C. M. 23 ACT GBG
410 FOURTH AVE., ALBANY 31705

HOLMES, DEAN LEE 74 ACT
524 SPARTA RD., SANDERSVILLE 31082

HOLMES, WILLIAM C. 4 OE2 FP
1207 JOHNS RD., AUGUSTA 30909

HOLT, EDWARD 56 ACT FP
807 N. PARRISH AVE., ADEL 31620

HOLTON, JOHN B. 29 ACT R
35 BUTLER ST., S.E., ATLANTA 30303

HOMEYER, W. F., JR. 6 ACT ANES
1654 TWIN PINES DR., MACON 31201

HOOD, E. O. 11 ACT FP
241 ABERCORN ST., SAVANNAH 31401

HOOD, HERB L. 23 ACT ANES
P. O. BOX 1826, ALBANY 31702

HOOPER, ROBERT J. 6 ACT CPH
645 FIRST STREET, MACON 31201

HOOSE, KENNETH A., JR. 22 ACT I
1276 MCCONNELL DR., DECATUR 30033

HOPKINS, RALPH O. 34 ACT R
HALL CO. HOSP., GAINESVILLE 30501

HOPKINS, WM. A. 29 ACT SU
1938 PEACHTREE RD., N. W. 303, ATL 30309

HOOSE, ELDON E. 22 ACT FP
3644 CHAMBLEE TUCKER RD., CHAMBLEE 30341

HORN, EDGAR B. 47 ACT SU
DOCTORS BLDG., COLUMBUS 31901

HORNBERGER, R. B. 29 ACT PATH
340 BOULEVARD, N. E., ATLANTA 30312

HORSEMAN, ROBERT W. 54 ACT ANES
BOX 2842, AUGUSTA 30904

HORTMAN, H. C. 27 ACT GBG
10 HOSPITAL CIR., ROME 30161

HOTALEN, WM. B. 2S ACT INO
3384 PTREE RD., N.E., ATLANTA 30326

HOUSE, JOHN C. 3 ACT FP
703 E. BROAD ST., WINDER 30680

HOUSER, FRANK M. 6 ACT FP
781 SPRING ST., MACON 31201

HOUSTON, JOSEPH S. 56 ACT P
305 EMORY ST., VALDOSTA 31603

HOWARD, CHARLES K. 2S A SL
5084 N. PEACHTREE, DUNWOODY 30338

HOWARD, EDWARD K. 47 ACT SL
MEDICAL CENTER, COLUMBUS 31902

HOWARD, JAMES W. 2S ACT FP
849 BATTLE CREEK RD., JONESBORO 30236

HOWARD, JOHN C. 11 ACT DALR
317 E. HALL STREET, SAVANNAH 31401

HOWARD, LEE, JR. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403

HOWARD, ROBERT M. 11 ACT PATH
P.O. BOX 133, SAVANNAH 31406

HOWARD, WILLIAM R. 2 ACT O
CENTRAL STATE HOSP., MILLEDGEVILLE 31062

HOWELL, BARBARA P. 2S ACT FP
620 PEACHTREE ST., N.E., ATLANTA 30308

HOWELL, EDGAR V., JR. 22 ACT CR
755 COLUMBIA CR., DECATUR 30030

HOWELL, TOM S., JR. 2S ACT SL
620 PEACHTREE ST., N.E., ATLANTA 30308

HOWELL, WM. HARVEY 4 ACT
41 NELSON ST., CARTERSVILLE 30120

HOWINGTON, JERRY W. 54 ACT R
UNIVERSITY HOSPITAL, AUGUSTA 30902

HOWLAND, W. SLOCUM, JR. 2S ACT CR
3250 HOWELL MILL RD., NW., ATLANTA 30327

HOWSE, RALPH M. 27 ACT L
1825 MARTHA BERRY HWY., ROME 30161

HUBBARD, DONALD E. 2S ACT CBG
35 COLLIER RD., N.W., ATLANTA 30309

HUBBARD, JAMES A. 23 ACT CBG
401 S. MADISON, ALBANY 31701

HUBBELL, ROBT. W. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033

HUBERT, M. A. 15 DE5 L
466 HIGHLAND AVE., ATHENS 30601

HUDGINS, HERBERT A. 2S S PH
50 SEVENTH ST., N.E., ATLANTA 30323

HUDGINS, WILLIAM BAIRD 2S ACT I
340 BOULEVARD, N. E., ATLANTA 30312

HUDSON, CARLTON B. 4 ACT R
15 WOODVIEW DR., CARTERSVILLE 30120

HUDSON, HAROLD J. 46 ACT FP
25 PERRY AVE., CAMILLA 31730

HUDSON, JACK 54 ACT FP
SOUTHGATE PLAZA, AUGUSTA 30906

HUDSON, JAMES B. 54 ACT I
TALMADGE MEM. HOSP., AUGUSTA 30902

HUDSON, RONALD M. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

HUDSON, W. LLOYD 47 ACT PD
PHYSICIANS BLDG., COLUMBUS 31901

HUFF, PRENTIS BAKER 22 ACT CR
755 COLUMBIA CR., DECATUR 30030

HUFF, THOMAS A. 54 ACT EN
MEDICAL COLLEGE OF GA., AUGUSTA 30904

HUFFMAN, GALEN C. 11 ACT P
P.O. BOX 3608, RADFORD, VA. 24141

HUG, CARL C., JR. 2S ACT ANES
69 BUTLER ST., S.E., ATLANTA 30303

HUGER, WILLIAM, JR. 2S ACT PL
35 COLLIER RD., N.W., ATLANTA 30309

HUGHES, ANDREW J. 6 ACT FP
3741 HOUSTON AVE., MACON 31201

HUGHES, D. JAMES 2S ACT I
755 COLUMBIA CR., DECATUR 30030

HUGHES, JOE L. 2S ACT CR
1311 CLEVELAND AVE., EAST POINT 30344

HUGHES, JOHN L. 54 ACT P
STEVENS CREEK RD.-F, MARTINEZ 30907

HUGHSTON, JACK C. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901

HUGULEY, CHAS. M., JR. 2S ACT I
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

HUIE, LYNN M. 71 ACT FP
MONROE 30655

HUIE, RALPH A., JR. 2S ACT I
774 CLEMONT RD., N.E., ATLANTA 30306

HULL, DAVID S. 54 ACT CPH
MEDICAL COLLEGE OF GA., AUGUSTA 30904

HULSEY, W. G. ACT
1115 MORNINGSIDE DR., PERRY 31069

HUMPHREYS, JOHN L. 2S ACT CPH
705 JUNIPER ST., N.E., ATLANTA 30308

HUMPHRIES, ARTHUR L., JR. 54 ACT SL
TALMADGE MEM. HOSP., AUGUSTA 30902

HUNNICUT, J. A. 15 OE5 FP
1070 S. MILLEDGE, ATHENS 30601

HUNT, JAMES 13 ACT FP
P. O. BOX 398, DULUTH 30136

HUNT, JESSE L. 30 ACT
BOX 151B, BRUNSWICK 31520

HUNT, THOMAS JEFFERSON 5S ACT SL
610 S. 8TH ST., GRIFFIN 30223

HUNTER, CONWAY W., JR. 2S ACT CBG
3250 HOWELL MILL RD., N.W., ATLANTA 30327

HURD, RICHARD A., JR. 2S A CR
145 COPELAND RD.,E-2, ATLANTA 30342

HURST, J. WILLIS 2S ACT I
69 BUTLER ST., S.E., ATLANTA 30303

HURST, JAMES B. 6 ACT PATH
BALDWIN COUNTY HOSP., MILLEDGEVILLE 31061

HURT, MARION W. 74 ACT FP
109 W. CHURCH ST., SANDERSVILLE 31082

HUSSEINI, MAJED W. 36 ACT ANES
P. O. BOX 886, TUSCALOOSA, ALA. 35401

HUTCHINSON, J. R. B. 2S ACT GTG
144 PONCE DE LEON AVE.,N.E., ATLANTA 30308

HUTCHINSON, W. L. 66 ACT OBG
311 S. LEWIS STREET, LAGRANGE 30240

HUTCHISON, NORTON H. 7C ACT FP
TRENTON 30752

HUTTENBACH, DIRK E. 17 ACT P
627 CHEROKEE ST., N.E., MARIETTA 30060

HYDEN, WM. U. 27 ACT
TRION 30753

HYORICK, JOHN T. 2S ACT OBG
960 JOHNSON FRY. RD., STE 245, ATL 30342

HYORICK, PETER 2S ACT OBG
2744 FELTON DR., EAST POINT 30344

HYERS, JOHN J. 2S ACT ANES
5 CHAUMNT SQ,CROSS CRK PKY, NW, ATL. 30327

HYMAN, BARRY N. 2S OE2 CPH
10119 BRIAR FOREST, HOLSTON, TX 77042

I

IHNEN, MENARD 54 ACT PATH
LAB., UNIVERSITY HOSPITAL, AUGUSTA 30902

INGLIS, E. P., JR. 17 ACT
1308 CHURCH STREET, MARIETTA 30062

INMAN, J. S., JR. 23 ACT OBG
907 N. JEFFERSON ST., ALBANY 31705

INMAN, WM. D., JR. 30 ACT FP
2700 PARKWOOD DR., BRUNSWICK 31520

INSIGNARES, MANUEL S. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001

IRELAND, CHARLES R. 6 ACT I
811 ORANGE TERR., MACON 31201

ISELE, ANTHONY F. 23 ACT PATH
P. O. BOX 1906, ALBANY 31702

ISENBERG, SIDNEY 2S ACT P
44 25TH ST., N.E., ATLANTA 30309

ISRAEL, PHILIP Z. 17 ACT SL
3001 S. COBB DR., S. E., SMYRNA 30080

IVEY, C. RAY, JR. 36 ACT FP
102 HOSPITAL DR., WARNER ROBINS 31093

IVEY, JOHN C. 2S OE5 SL
BOX 309, MEANSVILLE 30021

IZENSTARK, JOSEPH L. 2S A R
80 BUTLER ST. S.E., ATLANTA 30303

J

JACKSON, BILLY JOE 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501

JACKSON, GORDON W. 6 ACT OBG
380 HOSP. DR., MACON 31201

JACKSON, HENRY C. 45 ACT FP
MANCHESTER 31816

JACKSON, JAMES G. 54 ACT CR
1140 CRUIO PARK AVE., AUGUSTA 30904

JACKSON, JAMES W. 11 ACT SL
1 MED. ARTS CENTER, SAVANNAH 31405

JACKSON, J. H. 5S OE5 FP
10 MARKET ST., BARNESVILLE 30204

JACKSON, JOSEPH M. 24 ACT FP
MCCOY-JACKSON HOSPITAL, FOLKSTON 31539

JACKSON, ROBERT W. 65 AF CRS
P. O. BOX 978, THOMASVILLE 31792

JACKSON, THOMAS W. 27 ACT OBG
326 MC CALL BLVD., ROME 30161

JACKSON, ZACH W. 2S OE5 CPH
1956 N. RIDGEWAY RD., N.E., ATLANTA 30345

JACOBS, IVEY 72 ACT ALR
P. O. BOX 882, WAYCROSS 31501

JACOBS, JOHN L. 2S ACT AL
490 PEACHTREE ST., N.E., ATLANTA 30308

JACOBS, JULIAN 2S S I
VA HOSP., P. O. BOX 29457, ATLANTA 30329

JACOBS, L. DAVIS 72 ACT FP
403 LISTER ST., WAYCROSS 31501

JACOBS, LOUIS JERRY 2 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31062

JACOBSON, ALAN I. 17 ACT PATH
P. O. BOX 665, MABLETON 30059

JAFFE, STEVEN L. 2S ACT P
6500 VERNON WOODS DR., N.E., ATLANTA 30328

JAMES, C. W., JR. 6 ACT FP
3741 HOUSTON AVE., MACON 31206

JAMES, FLOYD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501

JAMES, LILLAS L. 6 ACT FP
729 PINE ST., MACON 31201

JAMES, W. SCOTT 2S ACT PD
275 CARPENTER DR., N.E., ATLANTA 30328

JANTER, THOMAS B. 22 ACT PD
4511 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341

JARDINA, PHILIP M. 22 ACT I
711 CHURCH ST., DECATUR 30030

JARDINE, DAN A. 18 ACT SL
DOUGLAS 31533

JARMAN, JULIAN A. 2S S SL
P. O. BOX 29457, ATLANTA 30329

JARRARD, GEORGE T. 20 ACT I
P. O. BOX 609, NEWNAN 30263

JARRAT, W. O. 6 ACT CPH
626 FIRST ST., MACON 31201

JARRELL, FLOYD C., JR. 47 ACT DALR
317 DOCTORS BLDG., COLUMBUS 31901

JARRELL, HAROLD G. 47 ACT OBG
629 20TH STREET, COLUMBUS 31904

JARRELL, ROBERT J. 15 ACT R
ATHENS GENERAL HOSP., ATHENS 30601

JARRELL, SHELBY E. 15 ACT EN
1230 BAXTER ST., ATHENS 30601

JARRETT, HENRY K., JR. 66 ACT L
113 EAST SECOND STREET, TIFTON 31794

JARRETT, WM. H. 29 ACT GPH
575 W. PEACHTREE ST., N. E., ATLANTA 30308

JARVIS, JACK R. 25 S P
P. O. BOX 29457, ATLANTA 30325

JEANS, PARK C., JR. 54 ACT GPH
1021 15TH ST., AUGUSTA 30902

JELENKO, CARL, III 54 ACT SL
TALMADGE MEM. HOSP., AUGUSTA 30902

JELKS, LOUIS R. 57 ACT SL
P. O. BOX 128, REIDSVILLE 30453

JENKINS, BEN H. 20 ACT OALR
P. O. BOX 1120, NEWNAN 30263

JENKINS, CHESTER W. 47 S P
MARTIN ARMY HOSP., FT. BENNING 31906

JENKINS, JAMES H. 27 ACT GBG
16 PROFESSIONAL COURT, ROME 30161

JENKINS, D. W. 27 R FP
LINDALE 30147

JENKINS, W. F. 47 DES R
1636 DIXON DR., COLUMBUS 31906

JENNINGS, C. M. 17 ACT I
641 CHURCH STREET, MARIETTA 30060

JENNINGS, E. R. 30 ACT SL
2432 PARKWOOD DR., BRUNSWICK 31520

JENNINGS, HENRY S., JR. 34 ACT I
710 BROAD ST., S.E., GAINESVILLE 30501

JENNINGS, JANE B. 11 ACT PATH
P. O. BOX 6688, SAVANNAH 31404

JENNINGS, ROBERT E. 58 ACT
ARLINGTON CITY HOSPITAL, ARLINGTON 31713

JENNINGS, W. C., JR. 54 ACT SL
V. A. HOSPITAL, AUGUSTA 30904

JERNIGAN, STERLING H. 25 ACT SL
710 PEACHTREE ST., N.E., ATLANTA 30308

JERNIGAN, WM. C. T. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904

JOEL, CHARLES, JR. 25 S N
1670 CLAIRMONT RD., N.E., DECATUR 30033

JOHN, FARES 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30904

JOHNS, CHARLES W. 6 ACT FP
3741 HOUSTON AVE., MACON 31206

JOHNSON, A. M. 56 ACT PD
DOCTORS BLDG., VALDOSTA 31603

JOHNSON, A. S., SR. 12 DES CALR
46 LAUREL DR., ELBERTON 30635

JOHNSON, A. S., JR. 12 ACT FP
LAUREL DR., ELBERTON 30635

JOHNSON, ALLYN C., JR. 34 ACT I
429 E. SPRING STREET, GAINESVILLE 30501

JOHNSON, C. D. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904

JOHNSON, CHARLES E. 25 ACT I
3250 HOWELL MILL RD., N.E., ATLANTA 30342

JOHNSON, CHARLES G. 25 ACT FP
4932 PHILLIPS DR., FOREST PARK 30050

JOHNSON, CLARENCE E., JR. 6 ACT SL
870 HIGH STREET, MACON 31201

JOHNSON, C. M. 30 ACT FP
520 OCEAN BLVD., ST. SIMONS IS. 31522

JOHNSON, C. V. 25 ACT P
2151 PEACHFORD RD., ATLANTA 30341

JOHNSON, E. G. 70 ACT SL
546 MCALLIE AVE., CHATTANOOGA, TENN. 37402

JOHNSON, EDWARD D. 25 ACT SL
3450 INTERNATIONAL BLVD., HAPEVILLE 30354

JOHNSON, EDWARD L. 22 ACT DR
2910 N. DRUID HILLS RD., ATLANTA 30329

JOHNSON, G. HUGO, JR. 11 DES
116 E. OGLETHORPE AVE., SAVANNAH 31401

JOHNSON, HENRY C., JR. 25 ACT R
35 COLLIER RD., N. W., ATLANTA 30309

JOHNSON, J. A. 45 DES FP
MANCHESTER 31816

JOHNSON, JIMPSEY B. 54 ACT R
MED. COLLEGE OF GEORGIA, AUGUSTA 30902

JOHNSON, JULIUS T. 54 ACT P
1467 HARPER ST., F, AUGUSTA 30902

JOHNSON, LEWIS D. 22 ACT I
4303 LAVISTA RD., TUCKER 30084

JOHNSON, L. MALCOLM 25 ACT FP
3450 INTERNATIONAL BLVD., HAPEVILLE 30354

JOHNSON, MARGARET W. 20 ACT PATH
P. O. BOX 20262, BIRMINGHAM, ALA 35216

JOHNSON, MARTIN L. 10 ACT
BOWDON 30108

JOHNSON, MARVIN E. 54 ACT PATH
1467 HARPER ST., AUGUSTA 30902

JOHNSON, MCCLAREN 25 ACT GE
478 PEACHTREE ST., N.E., ATLANTA 30308

JOHNSON, MILTON I., JR. 6 ACT FP
2605 CHEROKEE AVE., MACON 31204

JOHNSON, NORMAN, JR. 15 ACT PD
1010 PRINCE AVE., ATHENS 30601

JOHNSON, OTTO B., JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021

JOHNSON, R. JULIAN 25 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

JOHNSON, RICHARD HARDIN 25 ACT I
2045 PEACHTREE RD., N.E., ATLANTA 30309

JOHNSON, ROY J., JR. 5 ACT FP
MEDICAL ARTS BLDG., FITZGERALD 31750

JOHNSON, THOMAS D. 23 ACT I
P. O. BOX 288, ALBANY 31702

JOHNSTON, FRANK M. 11 ACT PN
P. O. BOX 13146, SAVANNAH 31404

JOHNSTON, G. A. 6 ACT
755 MONROE STREET, MACON 31201

JOHSTON, HARRY B., JR. 76 ACT SL
500 N. THIRD AVE., CHATSWORTH 30705

JOHNSTON, JOSEPH F. 34 ACT ANES
RED OAK DR., RT. 8, GAINESVILLE 30501

JOINER, HARTWELL 34 DES I
319 N. BRADFORD ST., GAINESVILLE 30501

JOINER, JAMES C., III 22 ACT CPH
755 COLUMBIA DR., DECATUR 30030

JOINER, R. M. 15 ACT PD
MOULTRIE 31768

JOINES, IVERSON W., II 25 ACT I
478 PEACHTREE ST., N.E., ATLANTA 30308

JOLLEY, FLEMING L. 25 ACT NS
EMORY CLINIC BUILDING, ATLANTA 30322

JONES, A. P. 55 ACT FP
P.O. BOX 741, GRIFFIN 30223

JONES, ARTHUR B., JR. 25 ACT CBG
401 PEACHTREE ST., N.E., ATLANTA 30308

JONES, CARL C., JR. 29 ACT AL
1285 PEACHTREE ST., N.E., ATLANTA 30309

JONES, CHARLES M. 25 A FP
NO CURRENT ADDRESS

JONES, E. LADD, JR. 25 ACT DR
3250 HOWELL MILL RD., N.W., ATLANTA 30327

JONES, EDWARD G. 42 S
VA HOSPITAL, DUBLIN 31021

JONES, ELLIS L. 25 A TS
EMORY UNIV. SCH. OF MED., ATLANTA 30322

JONES, ERNEST J. 22 ACT FP
2644 CANDLER PKWY., DECATUR 30030

JONES, FOREST D. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345

JONES, G. FRANK, JR. 54 ACT SL
2266 WRIGHTSBORO ROAD, AUGUSTA 30904

JONES, GEORGE R. 22 ACT
3596 CHAMBLEE TUCKER RD., CHAMBLEE 30341

JONES, GEORGE R. 6 ACT GPH
626 FIRST ST., MACON 31201

JONES, GEORGE W., JR. 25 ACT I
490 PEACHTREE ST., N. E., ATLANTA 30308

JONES, HENRY B., JR. 6 ACT
GRAY 31032

JONES, HERMAN O., PH.D. 25 H
DIR. CRIME LAB., P.O. BOX 1456,ATL 30301

JONES, HURLEY D., JR. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

JONES, J. SHERWOOD 76 ACT I
MEMORIAL DR., DALTON 30720

JONES, JOHN P. 6 ACT PD
885 PINE ST., MACON 31201

JONES, KENNETH D. 54 ACT P
EXEC. PK. F, SUITE 526, MARTINEZ 30907

JONES, LEWIS E. 25 S I
1670 CLAIRMONT RD., DECATUR 30033

JONES, MERWOOD M. 25 ACT CBG
2945 STONE HOGAN RD., CONN., ATL. 30331

JONES, R. E. 66 ACT FP
TIFTON 31794

JONES, RICHARD B. 25 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

JONES, ROBERT H. 6 ACT I
675 NEW ST., MACON 31201

JONES, ROBERT T. 70 ACT
LAFAYETTE 30728

JONES, RUDOLPH W., JR. 6 ACT I
883 PINE STREET, MACON 31201

JONES, W. R. 47 DES PD
3055 SAGE RD., HOUSTON, TEXAS 77000

JORDAN, CARL R. 11 ACT SL
P. O. BOX 3567, STA. B, SAVANNAH 31404

JORDAN, CHARLES G. 14 ACT FP
TATE CLINIC, TATE 30177

JORDAN, TOMMY H. 34 ACT P
500 SPRING ST., N.E., GAINESVILLE 30501

JORDAN, W. P. 47 DES L
2875 EDGEWOOD DRIVE, COLUMBUS 31906

JORDAN, W. DANIEL 25 ACT SL
490 PEACHTREE ST., STE 365-C, ATL 30308

JORDAN, WILLIAM K. 6 ACT CBG
675 NEW ST., MACON 31201

JOSEPH, ALFRED 25 ACT PD
1311 CLEVELAND AVE., EAST POINT 30344

JOSEPH, A. HAROLD 25 ACT L
3316 PIEDMONT RD., N.E., ATLANTA 30305

JOSEPHS, ALVIN D. 25 S I
P. O. BOX 29457, ATLANTA 30325

JOSEY, JOHN S. 30 ACT GPH
3010 HAMPTON AVE., BRUNSWICK 31520

JOSEY, WILLIAM E. 25 ACT CBG
1365 CLIFTON RD., N.E., ATLANTA 30322

JOVE, DONNA F. 25 ACT PATH
1216 ARBOR VISTA DR., N.E., ATLANTA 30329

JOVE, JULIO 22 ACT DR
3644 CHAMBLEE-TUCKER RD., CHAMBLEE 30341

JOWERS, J. R. 54 ACT FP
210 OAK ST., MARTINEZ 30907

JUDY, JAMES C. 11 ACT L
P.O. BOX 6555, SAVANNAH 31405

JUN, CHANNING S. 50 ACT SL
702 SECOND AVE. W., EASTMAN 31036

JURGENSEN, PAUL F. 11 ACT I
P. O. BOX 5086, SAVANNAH 31403

JURKIEWICZ, MAURICE J. 25 ACT PL
1365 CLIFTON RD., N.E., ATLANTA 30322

JUSTICE, DREN W. 70 ACT FP
LAFAYETTE MED. CTR., LAFAYETTE 30728

K

KAHLE, DAN BRUCE 25 ACT CBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

KAHN, S. DAVID 25 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

KAISER, RICHARD R. 17 ACT PD
3001 S. COBB DR., S. E., SMYRNA 30080

KANAVAGE, CHESTER B. 1 ACT SL
413 N. MAIN ST., BAXLEY 31513

KANTER, W. W. 11 ACT
P. O. BOX 9621, SAVANNAH 31402

KANTO, WILLIAM P., JR. 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30904

KAPLAN, JOEL A. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322

KARASU, SUAT 29 ACT ANES
627 CHEROKEE ST., MARIETTA 30060

KARP, HERBERT R. 29 ACT N
69 BUTLER STREET, SE, ATLANTA 30303

KARSTEN, MIKELL B. 66 ACT SL
P.O. BOX 989, TIFTON 31794

KATZ, MYRON M. 29 ACT CBG
259 ARROWHEAD BLVD., JONESBORO 30236

KAUFMANN, GARY E. 29 ACT NS
2550 WINDY HILL RD., S.E., MARIETTA 30062

KAUFMANN, JAMES A. 29 ACT I
950 W. PEACHTREE ST. N. W., ATLANTA 30309

KAVURI, SURENDRANATH 42 ACT PD
112 ROWE ST., DUBLIN 31021

KAY, FERDINAND V. 6 ACT FP
1221 NEWBERG AVE., MACON 31206

KAY, JAMES B., JR. 54 ACT L
1021 15TH ST., AUGUSTA 30901

KEEN, O. F. 6 DE5 SL
AMERICAN FEDERAL BLDG., MACON 31201

KEENAN, JOSEPH P. 54 I&R
9 BICKFORD ST., SIMSBURY, CT 06070

KEENER, ELLIS B. 22 ACT NS
365 WINN WAY, DECATUR 30030

KEETON, WILLIAM F. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

KEISLER, DAVID L. 54 A
MEDICAL COLLEGE OF GA., AUGUSTA 30904

KEITH, THOMAS L. 34 ACT ANES
ANES. ASSOC. OF GAINESVILLE, GAINESVI 30501

KEITH, W. PERRY 15 ACT EM
P.O. BOX 5898, ATHENS 30601

KELLEHER, ROBERT M. 17 ACT O
114 CHERRY ST., SUITE E, MARIETTA 30060

KELLER, A. PAUL, JR. 15 ACT CALR
1010 PRINCE AVE., ATHENS 30601

KELLEY, CHARLES N. 34 ACT I
710 BROAD ST., GAINESVILLE 30501

KELLEY, D. C. 13 DE5 FP
435 PERRY ST., S.W., LAWRENCEVILLE 30245

KELLEY, J. WELDON 59 ACT SL
602 S. 8TH ST., GRIFFIN 30223

KELLEY, ROBERT E., JR. 15 ACT CBG
740 PRINCE AVE., ATHENS 30601

KELLEY, W. A. 29 DE5 FP
478 PEACHTREE ST., N.E., ATLANTA 30308

KELLUM, J. M. 69 ACT SL
THOMASTON 30286

KELLY, ELMO C., III 6 ACT O
700 SPRING ST., MACON 31701

KELLY, GENE M. 6 ACT ANES
148 TEN KNOLLS DR., MACON 31204

KELLY, GORDON M. 54 ACT SL
1467 HARPER ST., AUGUSTA 30901

KELLY, JAMES C. 29 R SL
GENERAL MOTORS CORP., DORAVILLE 30340

KELLY, JAMES MARVIN 27 ACT GR
HARBIN CLINIC, ROME 30161

KELLY, JULIAN O., JR. 11 ACT CR
11 W. GORDON ST., SAVANNAH 31401

KELLY, ROBERT P., JR. 29 ACT OR
1365 CLIFTON RD., N. E., ATLANTA 30322

KELLY, WILLIAM D. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406

KEMBLE, JOHN W. 2 R N
704 RUNNYMEDE CIR., VA. BCH., VA. 23452

KEMPER, CLIFTON G. 29 DE5 FP
478 PEACHTREE ST., N.E., ATLANTA 30308

KENDRICK, DOUGLAS B. 29 A SL
3217 TETON DR., N.W., ATLANTA 30339

KENIMER, BARRY K. 34 ACT ANES
HALL COUNTY HOSP., GAINESVILLE 30501

KENNEDY, THOMAS E. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518

KENT, WILLIAM F. E ACT CBG
P. O. BOX 1066, STATESBORO 30458

KENT, WILLIAM R. 55 ACT FP
P. O. BOX 218, SYLVANIA 30467

KERLEY, CLIFFORD M. 22 ACT R
5247 FOREST SPRINGS DR., DUNWOODY 30338

KERR, WM. K. 22 ACT FP
P. O. BOX 80525, CHAMBLEE 30341

KESSLER, FRED OTTO, JR. 11 ACT FP
3802 WATERS AVE., SAVANNAH 31404

KETRON, HUBERT W. 29 S I
304 WORTHINGTON DR., MARIETTA 30060

KEULS, HANS A. 61 ACT CBG
1102 E. LAMAR ST., AMERICUS 31709

KIBLER, JAMES A. 42 ACT P
420 ACADEMY AVE., DUBLIN 31021

KIBLER, ROBERT F. 29 ACT I
69 BUTLER ST., S. E., ATLANTA 30303

KILEY, JAMES C. 29 ACT I
3250 HOWELL MILL RD., N.E., ATLANTA 30327

KILPATRICK, WM. F. 29 ACT CBG
1702 CLEVELAND AVE., EAST POINT 30344

KILPATRICK, ZACHARY M. 54 ACT GE
1467 HARPER ST., AUGUSTA 30902

KIM, CHYUNG M. 29 ACT PD
1468 S. INDIAN CREEK DR., ST. MT. 30083

KIM, H. HANK 29 ACT PD
2788 BAYARD ST., EAST POINT 30344

KIM, IN SOOK 10 ACT I
201 ALLEN MEMORIAL DR., BREMEN 30110

KIM, JONG-IN 29 ACT ANES
2760 FELTON DR., EAST POINT 30344

KIM, PYUNG JUNG 10 ACT SL
201 ALLEN MEMORIAL DR., BREMER 30110

KIM, SUNG H. 50 ACT PATH
GRIFFIN ST., EASTMAN 31023

KIM, TAE W. 23 ACT ER
2010 W. BROAD, ALBANY 31707

KIMMERLING, RICHARD W. 17 ACT SL
2404 AUSTELL RD., AUSTELL 30001

KINARD, GARLAND E. 70 ACT FP
118 HOWARD ST., ROSSVILLE 30741

KING, C. RICHARD 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

KING, GEORGE C. 60 ACT FP
BOX 307, CLAYTON 30525

KING, JAMES T. 29 OE1 ALR
3250 HOWELL MILL RD., N.W., ATLANTA 30327

KING, JAMES T., JR. 29 OE2 SL
14 INDEPENDENCE PLACE, ATLANTA 30318

KING, J. DUDLEY 29 ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

KING, JOHN LAMAR 59 ACT L
8TH STREET, GRIFFIN 30223

KING, J. L. 6 OE5 I
283 BUFORD PL., MACON 31201

KING, J. LON, JR. 6 ACT CBG
380 HOSP. DR., MACON 31201

KING, J. T. 65 ACT CALR
THOMASVILLE 31792

KING, JOHN T., JR. 65 ACT
P. O. BOX 1919, THOMASVILLE 31792

KING, OLIVER W. 17 ACT SL
3001 S. COBB DR., SMYRNA 30080

KING, RICHARD E. 29 ACT OR
340 BOULEVARD, N. E., ATLANTA 30312

KING, SPENCER B., III 29 ACT C
EMORY UNIV. CLINIC, ATLANTA 30322

KING, RUSKIN 11 DE5 PD
10 W. TAYLOR ST., SAVANNAH 31401

KING, STEPHEN 29 ACT PD
6500 VERNON WOODS DR., ATLANTA 30328

KING, STEPHEN H. 15 S I
NO CURRENT ADDRESS

KING, WM. R., JR. 59 ACT SL
708 S. 8TH STREET, GRIFFIN 30223

KINLAW, WM. K., JR. 22 ACT NS
365 WINN WAY, DECATUR 30030

KIRCHMAN, HERBERT 30 ACT
403 G. STREET, BRUNSWICK 31520

KIRCHNER, ARTHUR B. 29 ACT R
GRADY MEM. HOSP., ATLANTA 30303

KIRKLAND, JAMES J. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021

KIRKPATRICK, J. F., JR. 66 ACT SL
714 E. 18TH ST., TIFTON 31794

KIRKPATRICK, JAS L., JR. 17 A I
304 N. HILLCREST DR., MARIETTA 30062

KISER, ELLEN FINLEY 29 DE5 P
210 PEACHTREE CIR., N. E., ATLANTA 30309

KISER, WM. H., JR. 29 DE5 P
210 PEACHTREE CIR., N. E., ATLANTA 30309

KITAY, DAVID Z. 29 A CBG
80 BUTLER ST., S.E., ATLANTA 30303

KITCHENS, S. B. 70 OE5 FP
LAFAYETTE 30728

KITCHENS, WM. C. 15 ACT I
740 PRINCE AVE., ATHENS 30601

KITCHENS, WILLIAM R. 19 ACT SL
717 COLONIAL VILLAGE, MOULTRIE 31768

KITCHIN, HOUSTON W. 4 ACT FP
P. O. BOX 1006, CARTERSVILLE 30120

KITE, J. H. 29 DE5 CR
490 PEACHTREE ST. N. E., ATLANTA 30308

KLAUS, RICHARD M. 29 ACT CR
2550 WINDY HL. RD., STE. 208, MARIET 30062

KLEBER, RONALD J. 17 ACT P
84 LACY ST., MARIETTA 30060

KLEIMAN, SCOTT G. 17 ACT CR
3910 AUSTELL RD., AUSTELL 30001

KLEIN, LUELLA M. 29 ACT CBG
80 BUTLER ST., S. E., ATLANTA 30303

KLEMANN, GILBERT 54 ACT I
1021 15TH ST., AUGUSTA 30901

KLERIS, GEORGE S. 29 A PH
220 FORREST LK. DR., N.W., ATLANTA 30327

KLINGBEIL, ROBERT TAYLOR 17 ACT PM
KENNESTONE HOSP., MARIETTA 30060

KLOPPER, RALPH M. 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

KLOPSTOCK, WILLIAM J. 29 ACT P
3316 PIEDMONT RD., N.E., ATLANTA 30305

KLOTZ, HUGH A. 29 ACT CPH
3316 PIEDMONT RD., N.E., ATLANTA 30305

KLUGH, GEORGE F. 29 DE5 PATH
303 N. HORNER BLVD., SANFORD, N. C. 27330

KONAKCI, YUKSEL 29 A PATH
EMORY UNIV., ATL. 30322

KNELLER, SHELDON 47 S SL
MARTIN ARMY HOSP., FT. BENNING 31906

KNIGHT, EVELYN A. 22 ACT PD
3750 DIAL DR., CLARKSTON 30021

KNOWLES, VAN CISE 23 ACT SL
410 FOURTH AVE., ALBANY 31705

KNOWLTON, JAMES W. 60 ACT SL
800 E. DOYLE ST., TOCCOA 30577

KNOX, JOHN D., JR. 17 ACT GR
1416 CHEROKEE ST., MARIETTA 30062

KOCACITAK, SAHIN S. 70 ACT SL
TRI-COUNTY HOSP., FT. OGLETHORPE 30742

KOENIG, RONALD H. 29 ACT N
2739 FELTON DR., EAST POINT 30344

KONAKCI, YUKSEL 29 A PATH
NO CURRENT ADDRESS

KRAATZ, ROBERT 47 ACT PATH
1800 LAKEWOOD DR., PHENIX CITY AL 36867

KRAFKA, JOSEPH F. 68 ACT PATH
CITY CO. HOSP., VERNON RD., LAGRANGE 30240

KRAININ, MILITON JOSEPH 29 ACT I
1293 PEACHTREE ST., N.E., ATLANTA 30309

KRAL, ROBERT A. 2S ACT CBG
2100 PARKLAKE DR., N.E., ATLANTA 30345

KRAMER, JOHN F. 2S ACT CPH
4555 N. SHALLOWFORD RD., ATLANTA 30341

KRAMER, STEPHEN E. 2 OE1 P
LAKE SUNCLAIR, MILLEDGEVILLE 31062

KRANTZ, SIMON 2S S R
1670 CLAIRMONT RD., N. E., ATLANTA 30329

KRAVITZ, ALAN E. 2S ACT I
1938 PEACHTREE RD., N.W., ATLANTA 30309

KRAVTIN, A. J. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901

KREPPS, ARTHUR C., II 5S ACT CBG
503 S. 8TH ST., GRIFFIN 30223

KRUGMAN, PHILIP I. 2S ACT CBG
3312 PIEDMONT RD., N.E., ATLANTA 30305

KUGLER, MORRIS A. 11 ACT SL
1 MEDICAL ARTS CENTER, SAVANNAH 31405

KUMAR, SUSHIL V. 16 ACT FP
1019 ASTOR AVE., FOREST PARK 30050

KUGLER, MORRIS A. 11 ACT SL
1 MEDICAL ARTS CENTER, SAVANNAH 31405

KUMIN, GERALD O. 2S ACT I
644 CHEROKEE ST., MARIETTA 30062

KURTZ, JOSEPH L. 2S ACT CR
401 PEACHTREE ST., N.E., ATL. 30308

KURZBACH, ELMER 11 ACT FP
314 E. GASTON ST., SAVANNAH 31401

KUSHNAR, ROBERT L., JR. 17 ACT R
3001 S. COBB DR., SMYRNA 30080

KUSKE, TERRENCE T. 54 ACT I
MED COLLEGE OF GA., AUGUSTA 30904

KUTNER, STEPHEN S. 2S ACT CPH
340 BOULEVARD, N.E., ATLANTA 30312

KWON, OH BONG 15 ACT PD
1010 PRINCE AVE., ATHENS 30601

KYBURZ, BRUCE A. 17 ACT L
NO CURRENT ADDRESS

L

LABARBERA, ROBERT R. 64 ACT FP
PO BOX 98, HITCHCOCK HOSP., STRATTON 36743

LACKEY, DIXON A. 2S ACT PD
47 TRINITY AVE. S.W., ATLANTA 30334

LA CONTE, LEONARD P. 1S ACT R
MEMORIAL HOSP., MOULTRIE 31768

LA MOTTE, IRENE F. 54 ACT
1500 JOHNS RD., AUGUSTA 30904

LAHMAN, ROSE A. 2S ACT CBG
950 W. PEACHTREE ST., N. W., ATLANTA 30309

LAMB, CHARLES C. 23 ACT FP
910 N. JEFFERSON., ALBANY 31705

LAMBERT, ROBERT Y. 17 ACT SL
2241 LEWIS ST., KENNESAW 30144

LAMIS, PANO A. 2S ACT SL
314 BOULEVARD, N. E., ATLANTA 30312

LAMPROS, C. PETER 6C ACT R
800 COYLE ST., TOCCOA 30577

LANCASTER, HOMER H. 34 OE5 FP
P. O. BOX 651, GAINESVILLE 30501

LANGHAM, JACKSON W., JR. 5S ACT I
743 S. 8TH ST., GRIFFIN 30223

LANGY, MICHAEL S. 2S ACT I
2739 FELTON DR., EAST POINT 30344

LANE, DONALD R. 2S ACT I
353 PARKWAY DR., N. E., ATLANTA 30312

LANE, GEO M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

LANE, W. K. 23 ACT
806 14TH ST., ALBANY 31705

LANFORD, CHARLES A. 6 ACT FP
7405 IND. HWY., MACON 31206

LANG, LEWIS R. 31 ACT FP
CALHOUN 30701

LANGE, STEPHEN J. 11 ACT FP
509 LEE BLVD., SAVANNAH 31405

LANGE, STEPHEN J., JR. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

LANGFORD, JAMES F. 2S ACT FP
1143 ALPHARETTA ST., ROSWELL 30075

LANGSTON, WILLIAM T. 34 ACT PD
650 BROAD ST., S.E., GAINESVILLE 30501

LANIER, BOB G. 2S ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

LANIER, LONNIE R., JR. 11 ACT CBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405

LAOSA, MARIO DE O. 2 ACT SL
CENTRAL STATE HOSP., MILLEDGEVILLE 31062

LAPIDES, LEON 47 ACT ALR
309 DOCTORS BLDG., COLUMBUS 31901

LARAMORE, HERBERT F. 2S A PH
654 KIMBERLY LANE, N.E., ATLANTA 30306

LAROCHE, LAURENT P. 2S ACT OCM
2000 N.E. X-WAY, NORCROSS 30071

LAROSE, JAMES F. 2S ACT R
1170 CLEVELAND AVE., ATLANTA 30344

LASKY, RICHARD S. 7C ACT L
409 OOOO AVENUE, CHATTANOOGA TN 37404

LASLIE, MICHAEL N. 54 ACT ANES
MCG, AUGUSTA 30902

LASSITER, HOMER L. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713

LASSITER, NOLAN M. 22 ACT I
1275 MCCONNELL DR., DECATUR 30030

LATHAM, ELIZABETH B. 2S ACT PD
3185 WASHINGTON RD., EAST POINT 30344

LATHAN, SAMUEL R. 2S ACT I
1201 PTREE ST., N.E., ATLANTA 30361

LAU, FOOK S. 2 ACT I
CENTRAL STATE HOSP., MILLEDGEVILLE 31061

LAVIETES, PAUL A. 2S ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

LAWLER, JACK 47 ACT CBG
629 20TH ST., COLUMBUS 31904

LAWRENCE, GEORGE C. 2S ACT CBG
75 PIEDMONT AVE., N. E., ATLANTA 30303

LAWRENCE, JAMES D. 6 ACT SL
380 HOSP. DR., MACON 31201

LAWRENCE, JOHN C. 6C ACT PD
800 E. COYLE ST., TOCCOA 30577

LAWSON, QUENTIN T. 56 ACT L
401 WOODROW WILSON DR., VALDOSTA 31601

LAYNE, WILLIAM T. 17 ACT CBG
1676 MULKEY RD., AUSTELL 30001

LEADER, EDWARD 22 ACT P
1970 CLIFF VALLEY RD., N.E., ATLANTA 30329

LEAR, THOMAS F., JR. 65 ACT SL
P. O. BOX 1912, THOMASVILLE 31792

LEE, BOTHWELL G. 54 I&R
BOX 717, MCG, AUGUSTA 30902

LEE, F. LANSING 54 ACT I
1438 GWINNETT ST., AUGUSTA 30902

LEE, FRED M. 6C ACT L
800 E. COYLE ST., TOCCOA 30577

LEE, HOWARD B. 22 ACT FP
603 CHURCH ST., DECATUR 30030

LEE, DOROTHY S. JAEGER 2S ACT PD
1365 CLIFTON RD., N.E., ATLANTA 30322

LEE, JAMES MOULTRIE 11 ACT SL
200 E. 31ST. ST., SAVANNAH 31401

LEE, JOHN E. 2S ACT N
3312 PIEDMONT RD., N.E., ATL. 30305

LEE, JOSEPH D. 54 ACT SL
1021 15TH ST., AUGUSTA 30901

LEE, LAWRENCE, JR. 11 ACT I
2203 ABERCORN STREET, SAVANNAH 31401

LEE, MOO HEE 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902

LEE, WALTER E., JR. 72 ACT FP
BOX 737, WAYCROSS 31501

LEFKOFF, HAROLD J. 2S ACT CALR
340 BOULEVARD, N.E., ATLANTA 30312

LEGNER, STANLEY 7C ACT FP
7816 STONEHENGE DR., CHATTANOOGA, TN 37421

LEHMAN, RONALD J. 2S ACT OR
4555 N. SHALLOWFORD RD, CHAMBLEE 30341

LEIGH, JAMES F., JR. 34 ACT SL
194 GOLD ST., GAINSVILLE 30501

LEIGH, RICHARD W. 27 ACT CBG
16 PROFESSIONAL COURT, ROME 30161

LEIGH, TED F. 2S ACT R
1365 CLIFTON RD., N. E., ATLANTA 30322

LELAND, TOM W. 2S ACT P
2905 PEACHTREE RD., N.E., ATLANTA 30305

LEMLEY, JOHN W. 44 ACT FP
DOCTORS BLDG., THOMSON 30824

LEMON, ROMAN, JR. 54 ACT CBG
3651 WHEELER RD., AUGUSTA 30904

LENNON, ROBERT W. 16 ACT CPH
33 SW UPPER RYDLE RD., RIVEROALE 30274

LENTON, JOHN C. 2S ACT I
490 PEACHTREE ST., N. E., ATLANTA 30308

LEONARD, JAMES R. 2S ACT CTC
3250 HOWELL MILL RD., N. W., ATLANTA 30327

LEONARD, ROBERT 54 ACT CALR
1109 TELFAIR ST., AUGUSTA 30901

LEONARD, ROBERT P. 2S ACT PL
960 JOHNSON FERRY RD.,N.E., ATLANTA 30342

LEONARD, WILLIAM P. 2S ACT SL
3406 OLD PLANTATION RD., N.W., ATL 30327

LEONARDY, JOHN G. 2S ACT I
478 PEACHTREE ST., N.E., ATLANTA 30308

LEROY, ALBERT G. 44 ACT FP
THOMSON 30824

LESCHER, CHARLES F. 5S S R
14627 S.W. 63RD CT., MIAMI, FLA. 33158

LESESNE, ARTHUR E. 2S ACT I
353 PARKWAY, N.E., ATLANTA 30312

LESLIE, JAMES T. 22 A PD
50 SEVENTH ST., N.E., RM 404, ATL. 30323

LESSER, JOSEPH M. 2S ACT FP
490 PEACHTREE ST., N. E., ATLANTA 30308

LESSLIE, WILLIAM P. 17 ACT I
86 S. COBB DR., MARIETTA 30060

LESTER, JESS C. 2S ACT OPH
478 PEACHTREE STREET, N.E., ATLANTA 30308

LESTER, WM. M. 2S ACT OB
340 BOULEVARD, N.E., ATLANTA 30312

LETTON, A. HAMBLIN 2S ACT SL
315 BOULEVARD, N. E., ATLANTA 30312

LEVENSON, DAVID S. 22 ACT OPH
2754 N. DECATUR RD., DECATUR 30030

LEVERETT, EDWARD 6E ACT
432 GORDON CIRCLE, LA GRANGE 30240

LEVIN, HAROLD B. 2S ACT O
1293 PEACHTREE ST., N.E., ATLANTA 30309

LEVIN, JACK M. 2S ACT PR
340 BOULEVARD, N. E., ATLANTA 30312

LEVIN, RICHARD LESLIE 2S ACT O
3228 BRISTOL RD., CORNWELLS HGT., PA 19020

LEVINE, MICHAEL K. 2S ACT PD
6500 VERNON WOODS DR., N.E., ATLANTA 30328

LEVINE, STANLEY H. 2S ACT OBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

LEVINE, STEPHEN B. 2S ACT PD
5675 P'TREE-DUNWDY RD., N.E., ATL 30342

LEVY, CHARLES E. 2S ACT P
3400 PEACHTREE ST., N.E., ATLANTA 30326

LEVY, JACK H. 54 ACT R
1425 GWINNETT ST., AUGUSTA 30902

LEVY, LOUIS I. 76 ACT PD
1968 NORTH AVE., COLUMBUS 31901

LEVY, LOUIS K. 2S ACT I
1938 PEACHTREE RD., NW, ATLANTA 30309

LEVY, MORENO Y. 2S OE5 FP
221 ROBINHOOD RD., N.E., ATLANTA 30309

LEWIS, EARLE 68 DE1 I
303 SMITH ST., LAGRANGE 30240

LEWIS, EDWARD L., JR. 15 ACT O
1077 BAXTER ST., ATHENS 30601

LEWIS, ERNEST L. 29 ACT L
1365 CLIFTON RD., N. E., ATLANTA 30322

LEWIS, JOHN R., JR. 29 ACT PL
3316 PIEDMONT RD., N.E., ATLANTA 30305

LEWIS, L. K. 49 ACT
BOX 552, MADISON 30650

LEWIS, RONEL L. 49 S P
P. O. BOX 596, FT. BENNING 31905

LEWIS, WILEY B. 72 ACT FP
1507 ALICE ST., WAYCROSS 31501

LEWIS, WM. EARL 6 ACT SL
655-C FIRST ST., MACON 31201

LEYVA, JOSE S. 16 ACT OBG
33 UPPER RIVERDL RD. STE 214 RIVERDL 30274

LIEBELT, ROBERT A. 54 ACT ACM
N.W. OHIO UNIV. CLG-MED., KENT, OHIO 44240

LICHTMAN, STANLEY 29 ACT ANES
2760 FELTON DR., EAST POINT 30344

LIEVANO, ALVARO 29 ACT GR
1203 CLEVELAND AVE., EAST POINT 30344

LIGON, WALTER M. 17 ACT OTO
444 FAIRGROUND ST., MARIETTA 30060

LIN, HUI-CHING Y. 29 A I
634 WILSON RD., N.W., ATLANTA 30318

LIN, TA-JUNG 54 ACT OBG
MEDICAL COLLEGE OF GA., AUGUSTA 30902

LINDER, CHARLES H. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902

LINDLEY, JACK B. 54 ACT SL
1430 HARPER ST., AUGUSTA 30902

LINOSAY, JAMES B. 6 ACT SL
781 SPRING ST., MACON 31201

LINOSEY, I. LEHMAN, JR. 29 ACT R
3312 PIEDMONT RD., N. E., ATLANTA 30305

LINDSEY, MARK M. 17 ACT FP
155 TRAIL POINT, ATLANTA 30338

LINZ, WERNER A. 68 ACT L
303 SMITH ST., LAGRANGE 30240

LIPSIUS, L. H. 27 ACT P
HARBIN CLINIC, ROME 30161

LIPMAN, BERNARD S. 29 ACT I
1285 PEACHTREE ST., N.E., ATLANTA 30309

LIPPITT, WILLIAM H. 11 ACT SL
200 EAST 31ST STREET, SAVANNAH 31401

LIPSCOMB, GEORGE E. 47 ACT R
P. O. BOX 2787, COLUMBUS 31902

LIPSCOMB, J. WATTS 29 ACT I
6185 JONESBORO RD., MORROW 30260

LIPSCOMB, THOMAS L. 29 ACT
3450 INTERNATIONAL BLVD., HAPEVILLE 30354

LITTLE, ALEX G., JR. 56 ACT SL
RT. 1, BOX 4, VALDOSTA 31601

LITTLE, CHARLES H. 34 ACT GR
700 S. ENOTA DR., N.E., GAINESVILLE 30501

LITTLE, FRANK A. 65 ACT ANES
109 TUXEDO DR., THOMASVILLE 31792

LITTLE, G. H. 27 DE1 FP
TRION 30753

LITTLE, ROBERT C. 54 ACT C
MED COLLEGE OF GA., AUGUSTA 30904

LITTON, JAMES H. 22 ACT FP
4173 FIRST AVE., TUCKER 30084

LIU, PAUL I. 54 ACT PATH
MED. COLLEGE OF GA., AUGUSTA 30902

LLORENTE, TEODULO M. 27 ACT FP
13 JOHNS MADDOX DR., ROME 30161

LOBEL, A. BEATA 22 ACT PD
1275 MCCONNELL DR., DECATUR 30033

LOCHRIDGE, EDWIN P., JR. 29 ACT PR
35 COLLIER RD., N.W., ATLANTA 30309

LOFTMAN, BERT A. 29 ACT N
2718 FELTON DR., EAST POINT 30344

LOGAN, JAMES R. 11 ACT GTC
2203 ABERCORN ST., SAVANNAH 31401

LOGAN, WILLIAM DEWEY, JR. 29 ACT TS
272 BOULEVARD, N.E., ATLANTA 30312

LOGUE, H. EDWARD 54 DE2 FP
MED. COLLEGE OF GA., AUGUSTA 30902

LOGUE, R. BRUCE 29 ACT I
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

LONG, HAROLD G. 34 ACT
P. O. BOX 186, CAHLONEGA 30533

LONG, HAROLD W. 50 ACT FP
P. O. BOX 400, EASTMAN 31023

LONG, ROBERT F. 11 ACT R
P. O. BOX 6688, ST. C, SAVANNAH 31405

LONG, STEWART M. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

LONG, W. NEWTON 22 ACT OBG
80 BUTLER ST., S. E., ATLANTA 30303

LONG, W. V. 11 DE5 SL
103 E. JONES ST., SAVANNAH 31401

LONG, WILLIAM B. 29 ACT CPH
4303 LAVISTA RD., TUCKER 30084

LONGAKER, PAUL E. 6 ACT FP
4915-G RIVOLI DR., MACON 31204

LONGINO, GRADY E. 42 ACT I
VA CENTER, DUBLIN 31021

LOOPER, BEN KEITH 14 ACT OBG
CANTON 30114

LOPEZ, ERNESTO G. 72 ACT PATH
WAYCROSS MEM. HOSP., WAYCROSS 31501

LOPEZ, JOSE 29 ACT ANES
33 SW UPPER RIVERDALE RD., RIVERDALE 30274

LOPEZ, ORLANDO O. 29 ACT L
2748 FELTON DR., EAST POINT 30344

LORD, CLYDE O. 29 ACT ANES
501 FAIRBURN RD., S. W., ATLANTA 30331

LORENZ, MAX P. 17 ACT L
652 CHURCH ST., N. E., MARIETTA 30060

LOTT, OSCAR H. 11 DE1 FP
RFD RT. 2, DOUGLAS 31533

LOTT, THOMAS M. 54 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

LOTTERHOS, WILLIAM E. 54 ACT FP
MED. COLLEGE OF GA., AUGUSTA 30902

LOUGHLIN, EDWARD C. 29 ACT OR
3316 PIEDMONT RD., N.E., ATLANTA 30305

LOVE, WILLIAM G., JR. 47 ACT SL
P. O. BOX 6547, COLUMBUS 31907

LOVELL, WOOD W. 29 ACT GR
321 W. HILL ST., DECATUR 30030

LOVETT, KATHRYN S. 6 ACT P
P. O. BOX 486, STATESBORO 30458

LOVVORN, JOHN R. 27 ACT P
HARBIN CLINIC, ROME 30161

LOWANCE, DAVID C. 29 ACT I
1201 PEACHTREE ST., N.E., ATLANTA 30361

LOWANCE, MASON I. 29 ACT AL
3312 PIEDMONT RD., N. E., ATLANTA 30305

LOWENBERG, ROBERT I. 29 ACT SL
4444 AUSTELL RD., AUSTELL 30001

LOWERY, WILLIAM D., JR. 23 ACT NS
419 FOURTH AVE., ALBANY 31705

LUCAS, GEORGE W. 29 ACT SL
340 BOULEVARD, N.E., ATLANTA 30312

LUCAS, PAUL WARREN 66 ACT CALR
TIFTON 31794

LUCAS, WALLACE 36 ACT FP
613 E. DYKES ST., COCHRAN 31014

LUCAS, WILLIAM H. 27 ACT I
5 PROFESSIONAL CT., ROME 30163

LUCAS, WILLIAM T. 54 ACT L
1276 MERRY ST., AUGUSTA 30904

LUCKETT, JAMES M. 22 ACT R
2701 N. DECATUR RD., DECATUR 30030

LUKE, B. D. 16 ACT FP
6103 N. MAIN ST., MORROW 30260

LUKE, DANIEL R. 34 ACT FP
1144 VINE ST., N. E., GAINESVILLE 30501

LUMPKIN, MURRAY B. 76 ACT SL
P. O. BOX 987, DALTON 30720

LUMSDEN, THOMAS N. 33 ACT FP
P. O. BOX 45, CLARKESVILLE 30523

LUNSFORD, GUY G. 29 DE5 RET
2457 DREW VALLEY RD. N. E., ATLANTA 30319

LUPO, CARL W. 30 DE5 ALR
P. O. BOX 1057, ST. SIMONS ISLAND 31522

LUXENBERG, MALCOLM N. 54 ACT GR
1120 15TH ST., AUGUSTA 30902

LYNCH, LAWRENCE J., JR. 11 ACT SL
5102 PAULSEN ST., BLDG. F, SAVANNAH 31405

LYNOTT, MARJORIE A. 17 ACT FP
277 FAIRGROUND ST., MARIETTA 30060

LYON, DAVID B. 29 ACT P
490 PEACHTREE ST., N. E., ATLANTA 30308

LYON, HARRY C. 29 ACT FP
537 MORELAND AVENUE, S.E., ATLANTA 30316

LYON, JAMES B. 29 ACT OBG
2151 PEACHFORD RD., ATLANTA 30341

M

MABON, ROBERT 29 ACT NS
35 COLLIER RD., N.W., ATLANTA 30309

MACIAS, F. M. 59 ACT ANES
24 MAIN ST., HAMPTON 30228

MACCONELL, FRANK S. 29 ACT D
384 PEACHTREE ST., N.E., ATLANTA 30308

MACHADO, M. D. 29 ACT ANES
1676 MULKEY RD., AUSTELL 30001

MACKEY, DAN M. 22 ACT D
4511 CHAMBLEE DUNWOODY RD., ATLANTA 30319

MACNABB, GEORGE M. 20 ACT I
P.O. BOX 609, NEWNAN 30263

MACRIS, ALLEN G. 29 ACT TS
490 PEACHTREE ST., N. E., ATLANTA 30308

MACWILLIAMS, PETER 29 ACT O
1000 ATL. WEST BLVD., LITHIA SPRINGS 30057

MADDOX, S. F. 6 ACT OPH
800 FIRST ST., MACON 31201

MADDRY, EDGAR L. 42 S ADM
VA CENTER, DUBLIN 31021

MADRELL, ROBERT S. 68 ACT OBG
311 S. LEWIS ST., LA GRANGE 30240

MAGEE, KENNETH G. 22 ACT PD
4536 CHAMBLEE DUNWDY RD., ATLANTA 30341

MAGNAN, C. G., JR. 6 ACT PL
380 HOSP. DR., MACON 31201

MAGRUDER, RICHARD L., JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

MAHAN, D. R., JR. 76 ACT FP
MEMORIAL DR., DALTON 30720

MAHAN, THOMAS P. 29 ACT ANES
3518 PACES PLACE, N. W., ATLANTA 30305

MAHAYN, AHMAD S. 5 ACT SL
206 N. MAIN ST., FITZGERALD 31750

MAHONEY, PAUL D. 54 ACT ANES
3208 MONTPELIER DR., AUGUSTA 30904

MAINOR, ROBERT 17 ACT FP
2874 KING ST., S.E., SMYRNA 30080

MAJANOVIC, MAHMUD 2 ACT PLL
149 RIVERSIDE DR., MILLEDGEVILLE 31061

MAJOR, CECIL P. 68 ACT
303 SMITH STREET, LAGRANGE 30240

MAJOROS, MARTON 29 ACT ALR
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

MALLORY, JAMES D., JR. 29 ACT P
3355 LENOX RD., N. E., ATLANTA 30326

MALONE, RANDOLPH A. 65 ACT PD
413 GORDON AVENUE, THOMASVILLE 31792

MALONE, THOMAS P. 29 ACT P
6363 ROSWELL RD., N. E., ATLANTA 30328

MALONEY, GEORGE R. 54 ACT U
1467 HARPER ST., AUGUSTA 30902

MALOY, WILLIAM C. 29 ACT I
272 BOULEVARD, N.E., ATLANTA 30312

MANCHESTER, THOS. P., JR. 29 ACT OPH
35 COLLIER RD., N.W., ATLANTA 30309

MANER, FREDERICK DEBELE 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

MANGANIELLO, LOUIS O. J. 54 ACT NS
2247 WRIGHTSBORO RD., AUGUSTA 30902

MANGET, FRED P. 20 DE5
3372 OSBORNE PL., MACON 31204

MANGET, J. D., JR. 29 DE1 FP
26 THIRD ST., N.W., ATLANTA 30308

MANIS, ROBERT 29 ACT P
NO CURRENT ADDRESS

MANN, DAVID S. 6 ACT
645 FIRST STREET, MACON 31201

MANN, FRANK R., JR. 64 ACT
MCRAE 31055

MANNING, DONALD F. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

MANNING, JAMES HUNT 17 ACT SL
50 PLAZA WAY, MARIETTA 30060

MANNING, JOHANN R. 36 ACT CBG
105 BRIARCLIFF RD., WARNER ROBINS 31093

MANSBERGER, ARLIE 54 ACT GE
MCG, DEPT. SURGERY, AUGUSTA 30902

MANSFIELD, DONALD L. 22 ACT CBG
3576 CHAMBLEE TUCKER RD., CHAMBLEE 30341

MANSOUR, KAMAL A. 29 ACT TS
1365 CLIFTON RD., N.E., ATLANTA 30322

MANUS, RICHARD CHESLEY 17 ACT FP
166B MULKEY RD., AUSTELL 30001

MARCHMAN, MARVIN L. 13 ACT FP
1000 S. BUFORD HWY., NORCROSS 30071

MARCUCCI, MIGUEL A. 29 ACT VS
2404 AUSTELL RD., AUSTELL 30001

MARCUS, ROBERT D. 47 ACT GTG
1962 NORTH AVE., COLUMBUS 31901

MARCUS, NEAL W. 29 ACT CR
321 W. HILL ST., DECATUR 30030

MARINE, WILLIAM M. 29 A I
69 BUTLER ST. S.E., ATLANTA 30303

MARKLE, C. DAVID 17 ACT I
2271 AUSTELL RD., AUSTELL 30001

MARKHAM, JOHN C., III 54 ACT GE
1514 ANTHONY RD., AUGUSTA 30904

MARKS, THOMAS W. 29 ACT CR
340 BOULEVARD, N. E., ATLANTA 30312

MARLOW, JAMES E. 76 ACT FP
CLEVELAND HIGHWAY, DALTON 30720

MARRINER, E. F. 34 ACT CCM
CHICOPEE MFG. CO., GAINESVILLE 30501

MARSCHALK, F. F., JR. 54 ACT I
P. O. BOX 3803, AUGUSTA 30904

MARSHALL, A. SMOAK 36 ACT SL
725 N MACON ST., FORT VALLEY 31030

MARSHALL, LOUIE W. 54 ACT P
NO CURRENT ADDRESS

MARTENS, LESTER J. 27 ACT I
321 W. 7TH ST., ROME 30161

MARTENSON, EDGAR 11 ACT FP
42 MEDICAL ARTS, SAVANNAH 31405

MARTIN, DAN ALLEN 13 ACT SL
P. O. BOX 347, LAWRENCEVILLE 30245

MARTIN, ELISABETH 29 ACT CBG
P. O. BOX 946, CUMMING 30130

MARTIN, H. U. 76 ACT R
P. O. BOX 116E, DALTON 30720

MARTIN, JAMES B. 23 ACT CBG
707 N. JEFFERSON STREET, ALBANY 31705

MARTIN, J. D., JR. 29 A SL
230 ROBIN HOOD RD., N.E., ATLANTA 30309

MARTIN, JOHN M. 54 ACT I
1138 CRUID PARK AVE., AUGUSTA 30904

MARTIN, J. O. 6 ACT OPH
745 PINE ST., MACON 31201

MARTIN, LEE A. 34 ACT L
290 S. ENOTA DR., GAINESVILLE 30501

MARTIN, LOUIS G. 29 ACT R
793 CLIFTON RD. N.E., ATLANTA 30307

MARTIN, ROBERT B., III 53 ACT SL
201 RANDOLPH ST., CUTHBERT 31740

MARTIN, TALMADGE M. 10 ACT SL
619 DIXIE STREET, CARROLLTON 30117

MARTIN, WALTER D. 53 ACT FP
DAWSON 31742

MARTIN, WILLIAM O., III 29 ACT CPH
1938 PEACHTREE RD., N. W., ATLANTA 30309

MARTINEZ, A. C. 2 ACT I
P. O. BOX 677, MILLEDGEVILLE 31061

MARTINEZ, JOS. 72 ACT ANES
MEM. HOSP., WAYCROSS 31501

MARTINEZ, MARCIAL E. 56 ACT R
P. O. BOX 303, ADEL 31620

MARTYNSKI, STANISLAW 70 ACT PD
HUTCHESON MEM. HOSP., FT. OGLETHORPE 30742

MASHBURN, JAMES S. 13 ACT SL
P. O. BOX 668, CUMMING 30130

MASHBURN, MARCUS 13 DE5 FP
P. O. BOX 668, CUMMING 30130

MASHBURN, MARCUS, JR. 13 ACT CBG
P. O. BOX 668, CUMMING 30130

MASON, EDWARD MCK. 29 ACT SL
315 BLVD. N. E. STE. 532, ATLANTA 30312

MASON, JAMES L. 22 ACT P
1365 CLIFTON RD., N. E., ATLANTA 30322

MASON, M. H. 13 ACT FP
DULUTH 30136

MASON, W. ROY 29 ACT
EMORY UNIV. OFC. OF UNIV. PHY., ATL 30322

MASON, WILLIAM ALFRED 29 A PH
118 MARIETTA ST., N. W., ATLANTA 30303

MASSEE, JOSEPH C. 29 DE5 I
21 8TH ST. N. E., ATLANTA 30309

MASSENBURG, G. Y., JR. 6 ACT
700 SPRING ST., MACON 31201

MASSENGALE, L. R. 54 ACT PD
1903 ROCK SPRINGS DR., AUGUSTA 30904

MASSEY, JOE B. 29 ACT CBG
960 JOHNSON FERRY RD., ATLANTA 30342

MATHENY, JAMES T. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161

MATHEWS, WAYNE S. 22 ACT PD
2100 PARK LAKE CR., N.E., ATLANTA 30345

MATHEWS, WILLIAM F. 29 A PATH
EMORY UNIV-PATH DEPT., ATLANTA 30322

MATHIS, ERNEST H. 14 ACT CBG
CANTON MED. CTR., CANTON 30114

MATHIS, JAMES W. 56 ACT SL
209 PENDLETON DR., VALDOSTA 31601

MATHIS, W. H., JR. 17 ACT R
KENNESTONE HOSPITAL, MARIETTA 30061

MATTHEW, ROBERT A. 23 ACT ANES
P. O. BOX 1826, ALBANY 31702

MATTHEWS, LAWRENCE P. 22 DE5 CBG
1357 OXFORD RD., N. E., ATLANTA 30307

MATTHEWS, SANFORD JOHN 29 ACT PD
1938 PEACHTREE ROAD, N. W., ATLANTA 30309

MATTHEWS, W. FRANK 22 ACT PATH
DEKALB GENERAL HOSP., DECATUR 30030

MATTISON, RICHARD C. 22 ACT PI
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

MAUGHON, BOB R. 47 ACT PM
1953 SEVENTH AVE., COLUMBUS 31904

MAUGHON, JAMES S. 29 ACT SL
300 BLVD., N.E., ATLANTA 30312

MAULDIN, JOHN T. 29 ACT SL
315 BLVD. N. E., STE. 528, ATLANTA 30312

MAULDIN, JOHN W. 13 ACT FP
1081 29 HWY. S., LAWRENCEVILLE 30245

MAURIZI, CHARLES P. 6 ACT PATH
777 HEMLOCK ST., MACON 31201

MAXWELL, EDGAR J., JR. 44 ACT SL
W. HILL ST., THOMSON 30824

MAXWELL, JAMES W. 15 ACT PD
1010 PRINCE AVE., ATHENS 30601

MAXWELL, ROBERT B. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792

MAY, ROBERT D. 17 ACT U
50 PLAZA WAY, MARIETTA 30060

MAY, STEPHEN C., JR. 17 ACT FP
SOUTH MAIN STREET, KENNESAW 30144

MAYER, W. BREM, JR. 29 ACT N
3312 PIEDMONT RD., N. E., ATLANTA 30305

MAYES, ALVA LOUIE, JR. 6 ACT PD
2009 VINEVILLE AVE., MACON 31204

MAYFIELD, GEORGE R. 54 ACT I
2247 WRIGHTSBORO RD., AUGUSTA 30904

MAYHER, WILLIAM E., III 23 ACT NS
419 FOURTH AVE., ALBANY 31705

MAYO, EARL A., JR. 53 ACT
RICHLAND 31825

MAYO, EDWIN A. 30 ACT FP
2601 PARKWOOD DR., BRUNSWICK 31520

MAYS, ALDINE M., JR. 16 I&R FP
P. O. BOX 598, STOCKBRIDGE 30281

MAYS, J. R. S. 6 DE5 P
700 SPRING ST., MACON 31201

MAYS, J. LAMAR 29 ACT CPH
3200 HOWELL MILL RD., N.W., ATLANTA 30327

MAZO, MILTON 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405

MAZUR, W. P. 47 ACT P
P. O. BOX 6563, COLUMBUS 31907

MCALISTER, BRADWELL R. 34 ACT GR
650 BROAD ST., S.E., GAINESVILLE 30501

MCALLISTER, KATHRYN 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

MCALLISTER, ROBERT W. 6 ACT P
N. HOUSTON RD., A-1, WARNER ROBINS 31093

MCANULTY, MARTHA J. 22 ACT I
3390 PEACHTREE RD., N.E., ATLANTA 30326

MCARTHUR, CHARLES E. 26 DE5 FP
CORDELE 31015

MCARTHUR, JOHN C. 57 ACT
LYONS 30436

MCBRIDE, WALTER W. 17 ACT I
52 TOWER RD., MARIETTA 30062

MCCAIN, JOHN R. 29 ACT CBG
25 PRESCOTT ST., N. E., ATLANTA 30308

MCCALL, CHARLES S., JR. 23 ACT I
412 1/2 FOURTH AVE., ALBANY 31705

MCCALL, J. T., JR. 27 ACT SL
MCCALL CLINIC, ROME 30162

MCCARD, RAY H. 6 ACT P
596 ARLINGTON PL., MACON 31201

MCCARVER, W. C., JR. 34 ACT FP
400 PRIOR ST., S.E., GAINESVILLE 30501

MCCLARIN, WILLIAM M., JR. 72 ACT D
202 FOLKS ST., WAYCROSS 31501

MCCLELLAN, M. M., JR. 29 ACT PD
3776 DUMBARTON RD., N.W., ATLANTA 30327

MCCLELLAND, W. SPENCE 29 ACT I
478 PEACHTREE ST., N. E., ATLANTA 30308

MCCLURE, E. RUTH 17 ACT CBG
805 CAMPBELL HILL ST., MARIETTA 30062

MCCLURE, JOHN N. 29 ACT SL
25 PRESCOTT ST., N. E., ATLANTA 30308

MCCLURE, ROBERT E. 29 DE1
9201 S.W. 45TH ST., MIAMI, FLA. 33165

MCCOLLUM, R. ROY, JR. 24 ACT
BOX 356, KINGSLAND 31548

MCCOLLUM, WILLIAM 65 ACT
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

MCCORD, CLINTON C., JR. 29 ACT CPH
3280 HOWELL MILL RD., N. W., ATLANTA 30327

MCCORD, DALE L. 29 ACT R
25 PRESCOTT ST., N. E., ATLANTA 30308

MCCORD, JAMES W. 54 ACT N
1514 ANTHONY RD., AUGUSTA 30904

MCCORMICK, GLENN E., JR. 22 ACT D
755 COLUMBIA DR., DECATUR 30030

MCCOY, JOHN F. 19 ACT FP
MOULTRIE 31768

MCCOY, JOHN M. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

MCCRANIE, E. JAMES 54 ACT P
MEDICAL COLLEGE OF GA., AUGUSTA 30902

MCCRANIE, MARTHA S. 54 ACT P
TALMADGE MEM. HOSP., AUGUSTA 30902

MCCRARY, GEORGE ALFRED 6E ACT CR
303 SMITH ST., LA GRANGE 30240

MCCREE, OTIS W. 29 ACT FP
2945 STONE HOGAN RD., CONN. S.W. 30331

MCCROSKEY, MARION M. 29 ACT ANES
144 PONCE DE LEON AVE.,N.E., ATLANTA 30308

MCCRUM, B. A. 34 ACT OBG
420 E. BROAD ST., GAINESVILLE 30501

MCCUISTON, C. F. 22 ACT I
3610 CHAMBLEE-TUCKER RD., CHAMBLEE 30341

MCCULLY, JAMES G. 3C ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

MCCURCY, WILLIS T. 22 ACT FP
P. O. BOX 336, STONE MOUNTAIN 30083

MCDANIEL, J. G. 29 DE5 SL
820 W. WESLEY RD., N.W., ATLANTA 30327

MCDANIEL, J. Z. 23 ACT L
C & S BANK BLDG., ALBANY 31701

MCDANIEL, JAMES S. 29 S OBG
3043 WESTMINSTER CIR. N. W., ATL 30327

MCDANIEL, WILLIAM L., JR. 76 ACT FP
1205 MEMORIAL DR., DALTON 30720

MCDAVID, WILLIAM E., JR. 16 ACT R
P.O. BOX 21, RIVERDALE 30274

MCDEW, STEPHEN M. 11 ACT OBG
918 W. BROAD ST., SAVANNAH 31401

MCDONALD, H. P. 29 DE5 L
98 CURRIER ST., N. E., ATLANTA 30308

MCDONALD, J. J. 15 ACT SL
740 PRINCE AVE., ATHENS 30601

MCDONALD, JAMES K. 54 ACT P
810 13TH ST., AUGUSTA 30902

MCDONALD, LEWIS H. 29 ACT SL
490 PEACHTREE ST., N.E., ATLANTA 30308

MCDONALD, LAWRENCE P. 29 ACT L
1641 LONGWORTH OFC. BL., WASHINGTON 20515

MCDONALD, R. H. 2C OE5 SL
P. O. BOX 933, NEWNAN 30263

MCDONALD, ROBERT L. 29 ACT P
3390 PEACHTREE RD., N. E., ATLANTA 30326

MCDONOUGH, L. ALLEN 29 ACT PD
1036 LINDBERG CRIVE, N. E., ATLANTA 30324

MCDONOUGH, PAUL G. 54 ACT OBG
TALMADGE MEM. HOSP., AUGUSTA 30902

MCDOUGALL, WM. L., JR. 29 ACT L
3250 HOWELL MILL RD., N.W., ATLANTA 30327

MCDOWELL, CHARLES W., JR. 22 ACT OPH
542 CHURCH ST., DECATUR 30030

MCELHANNON, F. M. 15 ACT SU
740 PRINCE AVE., ATHENS 30601

MCEVER, V. W., JR. 3E ACT SU
212 HOSPITAL DR., WARNER ROBINS 31093

MCFADDEN, I. J., II 29 ACT P
6500 VERNON WOODS DR., N.E., ATLANTA 30328

MCFALL, VORIS F. 3E ACT SL
WESTVIEW ORS. BLDG., FORT VALLEY 31030

MCFARLAND, D. EDWARD 54 ACT PATH
UNIV. HOSP., WALTON WAY, AUGUSTA 30904

MCFARLIN, DALE E. 29 A I
69 BUTLER ST., S.E., ATLANTA 30303

MCGAHEE, OLLIE O., JR. 75 ACT FP
P. O. BOX 937, JESUP 31545

MCGAHEE, ROBERT C. 54 ACT PD
1429 GWINNETT ST., AUGUSTA 30902

MCGARITY, S. S., JR. 54 ACT P
1423 HARPER ST., AUGUSTA 30904

MCGARITY, WM. C. 29 ACT SL
1365 CLIFTON RD., N. E., ATLANTA 30322

MCGEARY, W. C., JR. 49 ACT FP
167 W. JEFFERSON ST., MADISON 30650

MCGEE, HARRY H., JR. 11 ACT R
311 E. HALL ST., SAVANNAH 31401

MCGEE, THEODORE J. 47 ACT SL
ST. FRANCIS MED. PK., COLUMBUS 31904

MCGEHEE, JOHN M. 27 OE1 SL
BOX 277, CEDARTOWN 30125

MCGHEE, EARL T. 76 ACT FP
BURLEYSON DR., DALTON 30720

MCGINNIS, LAMAR S., JR. 22 ACT SL
365 WINN WAY, DECATUR 30030

MCGINTY, A. PARK 29 ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

MCGINTY, W. R. 19 ACT SL
MOULTRIE 31768

MCGOLDRICK, THOMAS A., JR 11 ACT I
15 E. GORDON ST., SAVANNAH 31401

MCGOUGAN, M. T. 72 ACT SL
1921 ALICE ST., WAYCROSS 31501

MCGRAW, WALKER C. 29 ACT SL
4555 N. SHALLOWFORD RD., ATLANTA 30341

MCGUIRE, JAMES E. 17 ACT OBG
NO CURRENT ADDRESS

MCINNES, GEORGE F. 54 ACT PL
P.O. BOX 1668, WILMINGTON, DEL. 19899

MCKEMIE, W. FRANK 23 ACT
108 N. MONROE ST., ALBANY 31701

MCKENZIE, DONALD J. 65 ACT L
935 S. BROAD ST., THOMASVILLE 31792

MCKENZIE, WM. J., JR. 29 ACT OBG
1365 CLIFTON RD., N. E., ATLANTA 30322

MCKINNEY, ALEXANDER S. 29 ACT N
1365 CLIFTON RD., N. E., ATLANTA 30322

MCKINNEY, JAMES E. 76 ACT L
MEDICAL ARTS BLDG., DALTON 30720

MCKINNEY, RAY L. 23 ACT R
P.O. BOX 1924, ALBANY 31702

MCKINNON, FRANK W. 17 ACT OR
652 CHURCH ST., MARIETTA 30060

MCKNIGHT, ROBERT R. 54 ACT CR
1417 GWINNETT ST., AUGUSTA 30902

MCLANE, JOHN E. 22 ACT OBG
365 WINN WAY, DECATUR 30030

MCLAREN, JOHN R. 2 ACT R
1365 CLIFTON RD., N. E., ATLANTA 30322

MCLARTY, WILLIAM T., JR. 29 ACT P
1970 CLIFF VALLEY RD., N.E., ATLANTA 30329

MCLEAN, DONALD C. 29 ACT AL
1938 PEACHTREE RD., N.W., ATLANTA 30309

MCLEAN, FREDERICK L. 79 ACT FP
407 MCPHAUL ST., SYLVESTER 31791

MCLEAN, WM. R. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060

MCLENDON, F. EARL 29 ACT FP
75 PIEDMONT AVE., N.E., ATLANTA 30303

MCLENDON, HAROLD L. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117

MCLENDON, JOE L. 6 ACT CPH
P. O. BOX 956, MACON 31202

MCLENDON, JULIAN K. 10 ACT
405 ALABAMA AVENUE, BREMEN 30110

MCLENDON, REMBERT L. 23 ACT CR
803 N. JEFFERSON ST., ALBANY 31701

MCLEOD, JOHN W. 19 ACT SL
223 S. MAIN ST., MOULTRIE 31768

MCLEOD, WALLACE N. 29 ACT D
340 BOULEVARD, N.E., ATLANTA 30312

MCMICHAEL, ROBERT S. 6 ACT FP
2869 NAPIER AVENUE, MACON 31204

MCMILLAN, E. C., JR. 6 ACT SL
670 NEW ST., MACON 31201

MCMILLIAN, JAMES R. 27 ACT PD
HARBIN CLINIC, ROME 30161

MCNAIR, HAL 21 ACT FP
1500 E. SHOTWELL, BAINBRIDGE 31717

MCNAIR, WILLIAM P. 57 ACT FP
SOPERTON 30457

MCNAMARA, VIRGINIA P. 54 ACT OBG
MEDICAL COLL. OF GA., AUGUSTA 30902

MCNEELY, HENRY H. 6C ACT FP
TOCCOA 30577

MCNEILL, A. A., JR. 46 ACT
CAMILLA 31730

MCNIECE, ESTELLE 29 DE5 PD
11 SEVENTEENTH ST., N.E., ATLANTA 30309

MCNINCH, JOSEPH H. 29 A ADM
4565 ANGELO DR., N.E., ATLANTA 30319

MCPHEETERS, HAROLD L. 29 ACT P
130 SIXTH ST., N. W., ATLANTA 30313

MCPHERSON, JOHN H. T. 15 ACT SL
1010 PRINCE AVE., ATHENS 30601

MCRAE, A. T. 1E ACT SL
1004 W. WARD ST., DOUGLAS 31533

MCRAE, O. B. 64 ACT SL
MCRAE 31055

MCRAE, O. R., JR. 54 ACT SL
1427 GWINNETT ST., AUGUSTA 30902

MCRAE, L. C. 57 ACT FP
P. O. BOX 216, MT. VERNON 30445

MCREYNOLDS, B. A. 11 ACT SL
224 E. 46TH ST., SAVANNAH 31405

MEACHAM, JACK R. 27 ACT FP
P. O. BOX 160, SUMMERVILLE 30747

MEADERS, HENRY O. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060

MEADORS, JASON LAWRENCE 56 ACT R
P. O. BOX 2254, VALDOSTA 31601

MEADOWS, CARTER LEE 25 ACT SL
P. O. BOX 879, SWAINSBORO 30401

MEADOWS, NOAH O., JR. 17 ACT I
52 TOWER RD., MARIETTA 30060

MEALING, F. G. 54 DE5 I
301 SOUTHERN FINANCE BLDG., AUGUSTA 30902

MEDINA, LEONARDO F. 16 ACT L
217 ARROWHEAD BLVD., JONESBORO 30236

MEEHAN, PETER L. 29 OE4 OR
13913 FLINT ROCK RD., ROCKVILLE, MD. 20853

MEEKS, CALVIN STEWART, JR 1B ACT FP
DOUGLAS 31533

MEEKS, WILLIAM H. 54 ACT NS
1140 CRUID PARKS AVE., AUGUSTA 30902

MEES, DONALD E., JR. 22 OE2 R
NO CURRENT ADDRESS

MEIER, JOHN A. 23 ACT OR
803 N. JEFFERSON ST., ALBANY 31701

MEINE, FREDERICK J. 47 ACT R
1515 DARTMOUTH RD., COLUMBUS 31902

MELTZER, HAROLD O. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344

MELVIN, PERRY O. 36 ACT FP
124 HOSP. DR., WARNER ROBINS 31093

MENDELOFF, JOSEPH 29 S PATH
1670 CLAIRMONT RD., N. E., ATLANTA 30329

MENDENHALL, W. A. 22 OE5 FP
3830 CHAMBLEE-DUNWDY RD., CHAMBLEE 30341

MENDEZ, SALVADOR A. 2 ACT P
1006 RIVERBEND DR., MILLEDGEVILLE 31061

MENENDEZ, JACK F. 6 ACT SL
700 SPRING ST., MACON 31201

MERLIN, HARVEY E. 29 ACT L
2788 BAYARD ST., ATLANTA 30344

MERREN, DAVID D. 23 ACT L
802 N. JEFFERSON, ALBANY 31705

MORGAN, ROBERT T. 79 ACT FP
501 WESTBERRY ST., SYLVESTER 31791

MERRILL, ARTHUR J., JR. 25 ACT C
35 LINDEN AVE., ATLANTA 30308

MERRITT, CHARLES R. 10 ACT PD
107 CLINIC AVE., CARROLLTON 30117

MERRITT, GEORGE W. 57 ACT FP
300 ARLINGTON DR., VIDALIA 30474

MERRITT, HINTON J. 58 ACT FP
COLQUITT 31737

MERRITT, JAMES W. 58 ACT FP
COLQUITT 31737

MESERVE, FRANCIS BRUCE 36 ACT
121 N. DAVIS DR., WARNER ROBINS 31093

METTS, BETTY HOGAN 6 ACT ANES
723 CAPTAIN KELL DR., MACON 31204

METTS, JAMES C. 11 DES I
110 W. GASTON ST., SAVANNAH 31401

METTS, JAMES C., JR. 11 ACT I
110 W. GASTON ST., SAVANNAH 31401

METZGER, C. ROBERT, JR. 22 ACT PD
6 LAVISTA PERIMETER OFC. PK., TUCKER 30084

MEYER, BERNARD C. 54 ST
NO CURRENT ADDRESS

MICHAELS, JOHN 22 ACT PD
2100 PARK LAKE DR., N.E., ATLANTA 30329

MICKEL, CAREY A., JR. 12 ACT SL
35-7 CHESTNUT ST., ELBERTON 30635

MIDDLEBROOKS, T. W. 44 ACT FP
THOMSON 30824

MIDDLETON, MILTON G. 65 ACT
MENTAL HEALTH CENTER, THOMASVILLE 31792

MIHALOUITS, KARL S. 17 ACT P
3188 ATLANTA ST., SMYRNA 30080

MIKELL, JOEL E. 20 ACT R
COWETA GEN. HOSP., NEWNAN 30263

MILES, MARILYNN L. 36 ACT PD
1876 WATSON BLVD., WARNER ROBINS 31093

MILLEDGE, ROBERT D. 25 ACT R
1968 PEACHTREE RD., N.W., ATLANTA 30309

MILLER, ABRAHAM 54 ACT CBG
1270 MERRY STREET, AUGUSTA 30904

MILLER, CECIL L. 13 ACT
BUFORD MEDICAL CLINIC, BUFORD 30518

MILLER, FRANK R. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792

MILLER, GEORGE D. 25 ACT D
275 CARPENTER DR., N. E., ATLANTA 30328

MILLER, GORDON C. 47 ACT I
2300 MANCHESTER X-WAY, COLUMBUS 31904

MILLER, J. M. 56 ACT CBG
2307 N. PATTERSON ST., VALDOSTA 31603

MILLER, JOSEPH I. 25 ACT C
25 PRESCOTT ST. N. E., ATLANTA 30308

MILLER, LILA BONNER 25 ACT I
768 JUNIPER STREET, NE, ATLANTA 30308

MILLER, PRESTON R. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

MILLER, ROBERT E. 75 ACT
P. O. BOX 10, JESUP 31545

MILLER, WILLIAM A. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405

MILSAP, JAMES H., JR. 22 ACT R
2910 N. DRUID HILLS RD., ATLANTA 30329

MIMS, GEO. T., JR. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30064

MIMS, OSCAR M. 65 ACT I
THOMASVILLE 31792

MINNICH, WM. R. 25 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

MINOR, B. DONALD 22 ACT R
2256 SAGAMORE HILLS DR., DECATUR 30033

MINOR, H. W. 25 DES I
4665 PEACHTREE DUNWOODY RD., ATLANTA 30342

MINOR, JAMES B. 29 ACT I
960 JOHNSON FERRY RD. N.E., ATLANTA 30342

MITCHELL, CHARLES H. 54 R ANES
MEDICAL COLLEGE OF GA., AUGUSTA 30902

MITCHELL, FRANK B., JR. 30 ACT SL
3011 KEMBLE AVENUE, BRUNSWICK 31520

MITCHELL, J. T. 68 ACT R
CITY-COUNTY HOSPITAL, LAGRANGE 30240

MITCHELL, JAMES K., JR. 25 ACT ALR
6075 ROSWELL RD., N. W., ATLANTA 30328

MITCHELL, MARVIN A. 25 ACT SL
3250 POWELL MILL RD., ATLANTA 30327

MITCHELL, MARVIN M. 17 ACT CR
3910 AUSTELL RD., AUSTELL 30001

MITCHELL, OTIS C. 25 ACT CBG
217 ARROWHEAD BLVD., JONESBORO 30236

MITCHELL, P. ROBERT 17 ACT CBG
653 CHEROKEE ST. N.E., MARIETTA 30060

MITCHELL, W. C. 17 ACT FP
SMYRNA 30080

MITCHELL, WM. E. 25 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

MITCHELL, WM. E., JR. 25 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

MITCHENER, J. W. 54 ACT PATH
UNIVERSITY HOSP., AUGUSTA 30902

MIXON, GEORGE E. 5 ACT FP
BOX 246, OCILLA 31774

MIXSON, E. HARRY 56 ACT
DOCTORS BLDG., VALDOSTA 31603

MIXSON, JOYCE F., JR. 58 ACT CBG
105 DOCTORS BUILDING, VALDOSTA 31603

MODY, NATWAR J. 15 ACT PATH
797 COBB ST., ATHENS 30601

MOKAL, ALBERT J. 25 ACT R
35 LINDEN AVE., N.E., ATLANTA 30309

MOLKNER, KENNETH C. 25 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

MOLNAR, EDMUND M. 47 ACT SL
101 DOCTORS BLDG., COLUMBUS 31901

MOLYNEAUX, E. W. 68 ACT FP
HAMMETT BLDG., LAGRANGE 30240

MONCRIEF, W. M. 25 DES FP
3293 HUNTERDON WAY-SOMERSET, MARIETTA 30062

MONFORT, JOHN M. 25 DES I
HILTON HEAD ISLAND, S.C. 29928

MONTERO, ENRIQUE 59 ACT ANES
546 S. 8TH ST., GRIFFIN 30223

MONTES, ISMAEL G. 58 ACT SL
1605 SHOTWELL ST., BAINBRIDGE 31717

MONTGOMERY, R. C., II 61 ACT
BUTLER 31006

MONTGOMERY, THOMAS A. 15 ACT SL
1010 PRINCE AVE., ATHENS 30601

MOODY, RAYMOND A. 6 ACT FP
755 ORANGE ST., MACON 31201

MOODY, RICHARD A. 75 ACT
P. O. BOX 456, JESUP 31545

MOON, ELLIOTT C. 22 ACT CBG
5 LAVISTA PERIMETER PARK, TUCKER 30084

MOONEY, A. JOHN 8 ACT
P. O. BOX 527, STATESBORO 30458

MOORE, B. WALDO, JR. 25 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

MOORE, C. W. C. 27 ACT I
304 E. 2ND. AVE., ROME 30161

MOORE, CHARLES R. 15 ACT GPH
1303 FOURTH ST., S.W., MOULTRIE 31768

MOORE, CLIFF, JR. 27 ACT SL
P.O. BOX 1108, ROME 30161

MOORE, G. RICHARD 25 ACT GBG
1702 CLEVELAND AVE., EAST POINT 30344

MOORE, HAYWOOD L. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

MOORE, MEL T. 22 ACT
3646 MARKET ST., CLARKSTON 30021

MOORE, PERRY 2 ACT R
BALDWIN COUNTY HOSP., MILLEDGEVILLE 31061

MOORE, RICHARD W. 11 ACT FP
905 MONTGOMERY ST., SAVANNAH 31401

MOORE, VICTOR AUGUSTUS 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

MOORE, W. L. 27 DEC
NO CURRENT ADDRESS

MOORE, W. W. 25 ACT NS
1175 PEACHTREE ST., N.E., ATLANTA 30309

MOORE, WILLIAM L. 54 ACT I
VA HOSP., F-D-F, AUGUSTA 30904

MOORES, RUSSELL R. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

MOORHEAD, CHRISTIAN R. 25 ACT CBG
75 PIEDMONT AVE., N.E., ATLANTA 30303

MOORMAN, CLAUDE T., II 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

MORAN, MARTIN J. 25 ACT PD
275 CARPENTER DR., N. E., ATLANTA 30328

MORELAND, C. C. 71 ACT
WALTON CLINIC, MONROE 30655

MORELAND, ROBERT F., JR. 11 ACT FP
709 BONNYRIDGE ROAD, PT. WENTWORTH 31407

MORETZ, WILLIAM H. 54 ACT SL
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902

MORGAN, DAVID L. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345

MORGAN, FRANK E., JR. 22 ACT R
755 COLUMBIA DR., DECATUR 30030

MORGAN, HARVEY V. 11 ACT FP
1805 ABERCORN ST., SAVANNAH 31401

MORGAN, HORACE L. 25 ACT PM
1718 PEACHTREE RD., N.W., ATLANTA 30309

MORGAN, J. C. 68 DES SL
WEST POINT 31833

MORGAN, JAMES C., JR. 68 ACT GALR
P. O. BOX 590, WEST POINT 31833

MORGAN, JAMES W. 25 ACT SL
490 PEACHTREE ST., N.E., ATLANTA 30308

MORGAN, MARY E. 54 ACT I
VA HOSPITAL, AUGUSTA 30904

MORGAN, TOBBY S. 27 ACT GTC
15 JOHN MADDOX DR., ROME 30161

MORGAN, Z. V., JR. 22 ACT I
542 CHURCH ST., DECATUR 30030

MORRIS, A. J. 36 ACT SL
MONTEZUMA 31063

MORRIS, ALBERT L. 25 ACT FP
65 W. CAMPBELLTON, FAIRBURN 30213

MORRIS, LARRY A. 34 ACT PD
650 BROAD ST., S.E., GAINESVILLE 30501

MORRIS, T. W. 23 ACT FP
2203 NOTTINGHAM WAY, APT. 1, ALBANY 31707

MORRISON, CHARLES W. 11 ACT PL
11 MEDICAL ARTS CTR., SAVANNAH 31405

MORRISON, JOSEPH V., JR. 11 ACT PD
4 MEDICAL ARTS CTR., SAVANNAH 31405

MORRISON, WILLIAM N. 25 ACT L
340 BOULEVARD, N. E., ATLANTA 30312

MORSE, CHESTER W. 22 ACT I
711 CHURCH STREET, DECATUR 30030

MORTON, JOHN B. 42 ACT I
V. A. CENTER, DUBLIN 31021

MORTON, WILLIAM J. 25 ACT L
3646 CHAMBLEE TUCKER RD., CHAMBLEE 30341

MORTON, WM. J. 65 ACT
S. BROAD ST., CAIRO 31728

MOSELEY, TEDDY C. 22 ACT OBG
365 WINN WAY, DECATUR 30030

MOSELEY, THOMAS H. 56 ACT OBG
DOCTORS BLDG., VALDOSTA 31603

MOSS, BENJAMIN F., JR. 54 ACT PM
UNIVERSITY HOSPITAL, AUGUSTA 30902

MOSS, T. H. 27 ACT CBG
409 S. BROAD STREET, ROME 30161

MOSS, THOMAS H., JR. 27 ACT FP
409 S. BROAD ST., ROME 30161

MOSTELLAR, MARVOUS E. 25 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

MOUSSAKHANI, JOSEPH 22 ACT CBG
3041 ACCESS RO., N.E. EXP., CHAMBLEE 30341

MOYE, BEN H. 56 ACT CPH
3024 N. PATTERSON ST., VALDOSTA 31601

MOYE, R. J. 25 ACT FP
SWAINSBORO 30401

MOYER, LEROY N. 29 ACT OBG
1175 PEACHTREE ST., N.E., ATLANTA 30309

MULHERIN, C. S. 54 ACT SL
1527 GWINNETT ST., AUGUSTA 30904

MULHERIN, JOSEPH A. 11 ACT ANES
711 E. 44TH ST., SAVANNAH 31405

MULHERIN, JOSEPH L. 54 ACT SL
1467 HARPER ST., AUGUSTA 30902

MULHERIN, WILLIAM B. 15 ACT GR
125 KING AVE., ATHENS 30601

MULKEY, A. P. 6 ACT SL
110 E. COLLEGE AVE., MILLEN 30442

MULLER, GERALD B. 65 ACT CBG
918 S. BROAD ST., THOMASVILLE 31792

MULLINIKS, ROBERT C., JR. 17 ACT CBG
2404 AUSTELL RD., AUSTELL 30001

MULLINS, SPENCER G. 17 ACT SL
605 CAMPBELL HILL ST., MARIETTA 30062

MULLINS, WM. BERNARD 54 ACT PATH
1467 HARPER ST., AUGUSTA 30902

MULLIS, KENNETH L. 42 ACT FP
309 BELLEVUE AVE., DUBLIN 31021

MUNN, E. K. 47 DES OBG
2919 HAMILTON RD., COLUMBUS 31904

MUNNA, JOHN C. 29 ACT PL
3316 PIEDMONT RD., N.E., ATLANTA 30305

MUNOZ, JUANA L. 29 ACT PD
2732-B FELTON DR., EAST POINT 30344

MURDOCK, ROBERT N. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

MURPHEY, ALEX T. 54 ACT I
1134 CRUIO PARK AVENUE, AUGUSTA 30904

MURPHY, FRED E., JR. 65 ACT GR
THOMASVILLE 31792

MURPHY, HARVEY J. 11 ACT SL
5112 PAULSEN ST., SAVANNAH 31405

MURPHY, MICHAEL J. 54 ACT OPH
1502 ANTHONY RD., AUGUSTA 30904

MURPHY, MICHAEL V., JR. 29 ACT I
21 8TH ST., N.E., ATLANTA 30309

MURPHY, RALPH A., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

MURPHY, WILLIAM R. 54 ACT PATH
622 MAGNOLIA, S. E., AIKEN, S. C. 29801

MURRAY, B. LAMAR 9 ACT
FOURTH ST., WAYNESBORO 30830

MURRAY, DARRELL W. 17 ACT FP
355 OLD POWDER SPRINGS RD, MABLETON 30059

MURRAY, DOUGLAS R. 29 ACT SL
1365 CLIFTON RD., N. E., ATLANTA 30322

MURRAY, HAMIL 34 ACT PATH
HALL COUNTY HOSPITAL, GAINESVILLE 30501

MURTHY, B. R. KRISHNA 15 ACT I
GRANT PLAZA, MOULTRIE 31768

MUSARRA, E. A. 17 ACT FP
220 CHURCH ST., MARIETTA 30060

MUSE, A. O., JR. 15 ACT SL
740 PRINCE AVE., ATHENS 30601

MUSHET, G. R. 54 ACT N
1003 CHAFEE AVE., AUGUSTA 30901

MUSSER, ELLYN Z. 17 ACT PD
277 PAT MELL RD., S.E., MARIETTA 30060

MYERS, ALBERT A. 13 ACT FP
51 S. PTREE ST., NORCROSS 30771

MYERS, JAMES S. 76 ACT R
P. O. BOX 1285, DALTON 30720

N

NADAL, GUILLERMO 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

NAHMIAS, ANDRE J. 29 A PD
69 BUTLER ST., S.E., ATLANTA 30303

NAIB, Z. M. 22 ACT PATH
80 BUTLER ST., S.E., ATLANTA 30303

NAIK, MADHAV V. 68 ACT SL
ENOCH CALLAWAY CANCER CN, LAGRANGE 30240

NAMER, JOSE B. 16 ACT FP&P
259 ARROWHEAD BLVD., JONESBORO 30236

NANCE, DANA W. 17 ACT SL
142 COUNTRY CLUB DR.,NEW ORLEANS, LA 70124

NAPOLI, VICTOR M. 29 ACT PATH
80 BUTLER ST., S.E., ATLANTA 30303

NASH, O. A. 11 ACT FP
5720 COLONIAL DR., SAVANNAH 31406

NASH, H. E., SR. 29 DES FP
250 AUBURN AVENUE, N.E., ATLANTA 30303

NASSAR, G. F. 29 ACT CBG
2739 FELTON DR., EAST POINT 30344

NATHAN, DANIEL E. 36 ACT FP
FORT VALLEY 31030

NATION, THOMAS C. 56 ACT PATH
DOCTORS BLDG., VALDOSTA 31601

NAZLI, MEHMET H. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001

NEAL, JULE C., JR. 6 ACT OBG
380 HOSP. DR., MACON 31201

NEEL, JULIAN B. 65 ACT SL
207 E. JACKSON ST., THOMASVILLE 31792

NEELD, JOHN B. 29 ACT ANES
2620 MEADOWLAWN DR., MARIETTA 30062

NEELY, F. LEVERING 29 ACT I
193B PEACHTREE RD., NW, ATL 30309

NEIGHBORS, J. B., JR. 15 ACT I
1010 PRINCE AVE., ATHENS 30601

NELKEN, VIOLA D. 47 ACT ANES
DOCTORS BUILDING, COLUMBUS 31901

NELSON, ALVAH J., III 28 DE2 R
14735 CINOYWOOD, HOUSTON, TEXAS 77024

NELSON, FRED L., JR. 56 ACT R
NASHVILLE, GA. 31639

NELSON, GEORGE H. 54 ACT CBG
MED. COLLEGE OF GA., AUGUSTA 30902

NELSON, HOMER S. 6 ACT CPH
BOX 956, MACON 31202

NELSON, MAYNARD 54 ACT SL
1502 ANTHONY RD., AUGUSTA 30904

NESBITT, ROBERT R., JR. 54 ACT SL
MED. COLLEGE OF GA, AUGUSTA 30902

NETTLES, JOE L. 11 ACT GR
P. O. BOX 6156, SAVANNAH 31405

NEUBERG, S. CHARLOTTE 6 ACT
608 AMERICAN FEDERAL BLDG., MACON 31201

NEUFELD, JOCELYN R. 15 ACT ANES
135 GATEWOOD PL., ATHENS 30601

NEVILLE, RUFUS L., JR. 11 ACT L
2115 BULL ST., SAVANNAH 31401

NEWBERRY, DAN C. 47 ACT ANES
DOCTORS BLDG., COLUMBUS 31901

NEWLIN, LUCIAN K. 56 ACT
307 E. JANE ST., VALDOSTA 31601

NEWMAN, HARVEY M. 34 ACT PD
650 BROAD ST. S.E., GAINESVILLE 30501

NEWMAN, W. A. 6 DES GR
4-D MASSEE APTS., MACON 31201

NEWSOM, BRUCE C. 47 ACT SL
633 19TH ST., COLUMBUS 31901

NEWSOM, NEAL F. 29 ACT CBG
2045 PEACHTREE RD., N.E., ATLANTA 30309

NEWSOM, N. J. 74 DES I
P. O. BOX 704, SANDERSVILLE 31082

NEWTON, JOHN S. 47 ACT OPH
317 DOCTORS BLDG., AUGUSTA 30902

NEWTON, MILLEGE C. 6 ACT I
380 HOSPITAL DR., MACON 31201

NEWTON, RALPH G., JR. 6 ACT L
718 FIRST ST., MACON 31201

NEWTON, W. M., JR. 15 ACT I
MED. CTR., THOMASVILLE HWY, MOULTRIE 31768

NEWTON, W. R. 6 ACT
801 SPRING ST., MACON 31201

NEWTON, Z. B., III 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

NICHOLAS, EDMUND M. 29 ACT L
401 PEACHTREE ST., N.E., ATLANTA 30308

NICHOLS, DAVID M. 22 ACT P
2871 CRAVEY DR., ATLANTA 30345

NICHOLS, EVANS J. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060

NICHOLS, FENWICK T., JR. 11 ACT I
P. O. BOX 6167, SAVANNAH 31405

NICHOLS, JOSEPH J. 29 ACT PR
490 PEACHTREE ST., N. E., ATLANTA 30308

NICHOLS, POMEROY 54 ACT NS
1521 POPE AVE., AUGUSTA 30904

NICHOLS, W. H. 14 ACT
CANTON 30114

NICHOLSON, GEORGE T. 33 ACT FP
CORNELIA 30531

NICHOLSON, W. LANIER 34 ACT FP
HIAWASSEE 30546

NICKERSON, JOHN F. 29 ACT PATH
35 LINDEN AVE., N.E., ATLANTA 30308

NICOLSON, WM. P., III 29 ACT L
35 COLLIER RD., N.W., ATLANTA 30309

NILES, GEORGE A., JR. 29 ACT OBG
1938 PEACHTREE RD., N.W., ATLANTA 30309

NINCIC, ALEXANDER 29 ACT L
490 PEACHTREE ST., N.E., ATLANTA 30308

NINO, HOMERO F. 29 S R
P. O. BOX 33525, DECATUR 30033

NIPPERT, PHILIP F. 29 ACT O
478 PEACHTREE ST., N.E., ATLANTA 30308

NIX, DILLARD L. 15 ACT CALR
1010 PRINCE AVENUE, ATHENS 30601

NIXON, DANIEL W. 54 ACT GA
MEDICAL COLLEGE OF GA., AUGUSTA 30904

NOBLE, CARL W. 30 A FP
205 1/2 MALLORY ST., SIMONS ISL. 31522

NODAL, RONALDO R. 22 ACT CBG
7 LA VISTA PER. OFC. PK., TUCKER 30084

NOLAN, THOMAS R. 29 ACT SL
2788 BAYARD ST., EAST POINT 30344

NORA, FELICIANO C. 27 ACT SL
FLOYD HOSP., ROME 30101

NORMAN, LEWIS C., JR. 68 ACT SL
WEST POINT 31833

NORTH, ALVIN W. 29 ACT OPH
575 W. PEACHTREE ST., N. E., ATLANTA 30308

NORTHUP, JOHN O. 11 ACT GE
5705 PAULSEN ST., STE 125, SAVANNAH 31405

NORTON, R. F. 27 ACT CBG
10 HOSPITAL CIR., ROME 30161

NORWOOD, SAM W. 29 ACT CBG
564 LEE ST., S. W., ATLANTA 30310

NORWOOD, WM. F. 29 ACT PD
3158 MAPLE DR., N.E., ATLANTA 30305

NOWELL, DAVID M. 76 ACT CBG
P. O. BOX 1136, DALTON 30720

NUNEZ, WILLIAM O. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344

NUTT, RICHARD L. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31603

NUTTALL, ROBERT P. 17 ACT FP
123 GORDON RD., MABLETON 30059

NUTTER, DONALD O. 29 A I
69 BUTLER ST., S.E., ATLANTA 30303

O

OBRIEN, DAVID P. 2S ACT L
1365 CLIFTON RD., N.E., ATLANTA 30322

OBRIEN, MARK S. 2S ACT NS
1365 CLIFTON RD., N.E., ATLANTA 30322

OCONNELL, MICHAEL J. 72 ACT GR
1507 ALICE ST., WAYCROSS 31501

ODANIEL, J. F. 42 ACT FP
1D7 ROWE ST., DUBLIN 31021

ODOM, HART S. 47 ACT
P.O. BOX 2299, COLUMBUS 31902

OGLESBY, JAMES W. 23 ACT TS
910 N. JEFFERSON ST., ALBANY 31705

OKEL, BENJAMIN B. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033

OKUN, PHILIP 17 I&R P
NO CURRENT ADDRESS

OLANSKY, MARIAN F. 2S ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322

OLANSKY, SIDNEY 2S ACT D
EMORY UNIV. CLINIC, ATLANTA 30322

OLOHAM, HARRY M., JR. 54 ACT OBG
1501 ANTHONY RD., AUGUSTA 30904

OLIVEIRA, EDUARDO 24 ACT SL
3D4 OSBORNE ST., ST. MARYS 31558

OLIVER, ROBERT LEE 11 DES SL
DE RENNE APTS., SAVANNAH 31401

OLIVER, ROBERT W., JR. 42 ACT SU
50B ACADEMY AVE., DUBLIN 31021

OLKOWSKI, Z. L. 22 A R
WINSHIP CLINIC, EMORY UNIV., ATLANTA 30322

OLLER, JOSEPH L. 54 ACT ANES
B12 13TH ST., AUGUSTA 30901

OLNICK, HERBERT M. 6 RET R
724 HEMLOCK ST., MACON 31201

OLSON, CLYDE L. 11 ACT OPH
P. O. BOX 8905, SAVANNAH 31402

ONEAL, BUFORD L. 2S ACT CALR
47B PEACHTREE ST., N. E., ATLANTA 30308

ONEAL, JOHN B., III 12 ACT SL
33 CHESTNUT ST., ELBERTON 30635

ONEAL, PHYLLIS J. 12 ACT I
33 CHESTNUT ST., ELBERTON 30635

ONEAL, R. S. 6B DES FP
LAGRANGE 30240

OOSTERHOUDT, JAMES J. 7E ACT SL
P. O. BOX 924, DALTON 30720

OQUIN, WILLIAM P. 22 ACT FP
2140 HENDERSON MILL RD., ATLANTA 30345

OQUINN, JAMES L. 54 ACT PATH
3651 WHEELER RD, AUGUSTA 30904

OREAR, HARRY B. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ORFUSS, CARL J. 2S ACT N
340 BOULEVARD, N.E., ATLANTA 30312

ORDSZ, JUDY I. 4 ACT PD
19 NELSON ST., CARTERSVILLE 30120

ORR, WILLIAM W. 6 ACT PD
2009 VINEVILLE AVE., MACON 31204

ORTEGA, HERNANDO JOSE 2S ACT SL
2958 RAINBOW DR., DECATUR 30034

ORTIZ, JESUS 11 ACT P
5105 PAULSEN ST., SAVANNAH 31405

OSBORNE, E. S. 11 DES CALR
P.O. BOX 870, SAVANNAH BEACH 31328

OSBORNE, ELTON S., JR. 2S ACT I
47 TRINITY AVE., S. W., ATLANTA 30334

OSBORNE, HORACE F. 54 ACT ANES
3609 NASSAU DR., AUGUSTA 30904

OSBORNE, W. W. 11 ACT OBG
11B E. 35TH ST., SAVANNAH 31401

OSHAUGHNESSEY, W. JHN JR. 6 ACT I
724 HEMLOCK ST., MACON 31201

OSHLAG, ABRAHAM M. 5S ACT I
3175 HILL STREET, GRIFFIN 30223

OSTA, SALIM M. 3C ACT GN
520 OCEAN BLVD., ST. SIMONS IS. 31522

OSTEEN, CLARK L. 11 ACT ANES
206 W. BAY ST., SAVANNAH 31401

OTEIZA, JORGE A. 56 ACT FP
2D0B WIMBLETON DR., THOMASVILLE 31792

OTIS, JOHN B. 2S ACT PATH
340 BOULEVARD, N.E., ATLANTA 30312

OTKEN, LUTHER B., JR. 54 ACT PATH
TALMADGE MEM. HOSP., AUGUSTA 30902

OVERTON, JOHN W., JR. 2S ACT EM
1170 CLEVELAND AVE., EAST POINT 30344

OXFORD, WILLIAM M. 6S ACT SL
405 W. MAIN ST., THOMASTON 30297

OWEN, RALPH G. 54 ACT OBG
15D2 ANTHONY RD., AUGUSTA 30904

OWENS, B. G. 56 DES SL
111 E. ALDEN AVE., VALDOSTA 31603

OWENS, JOS. L. 3C ACT TS
3010 HAMPTON AVE., BRUNSWICK 31520

OWINGS, RICHARD S. 54 ACT PD
1467 HARPER ST., AUGUSTA 30902

P

PACIFICI, JOSEPH 11 ACT FP
2 E. TAYLOR ST., SAVANNAH 31401

PACKER, ROBERT M., JR. 72 ACT I
P.O. BOX B99, WAYCROSS 31501

PAGE, JOHN A. 6 ACT OPH
800 FIRST ST., MACON 31201

PAGSISIHAN, FRANCISCO H. 4S ACT SL
P.O. BOX 1D, MADISON 30650

PALAY, BERNARD H. 2S ACT I
1175 PEACHTREE ST., N. E., ATLANTA 30309

PALMER, E. CAPERS, JR. 2S ACT PATH
35 LINDEN AVE., N.E., ATLANTA 30308

PALMER, FRED L. 4E ACT R
ROUTE 4, COVINGTON 30209

PALMER, JACK R. 1S ACT
1D1D PRINCE AVE., E. ATHENS 30601

PALMER, JAMES D. 2S ACT I
970 HUNTER STREET, S.W., ATLANTA 30314

PALMER, JOHN R. 54 ACT OR
MED. COLLEGE OF GA., AUGUSTA 30904

PALMER, J. GARY, JR. 17 ACT L
823 CAMPBELL HILL ST., MARIETTA 30060

PARUNGAO, ROMULO L. 2S ACT SL
1235 SALEM GATEWAY, CONYERS 30207

PARHAM, ROBERT E. 17 ACT N
670 CHEROKEE ST., N.E., MARIETTA 30060

PARKER, GREGG 23 ACT OBG
4D1-B MADISON AVE., ALBANY 31707

PARKER, J. LEE 4S ACT FP
GREENSBORO 30642

PARKER, PRENTISS E., JR. 17 ACT OBG
30D1 S. COBB DR., SMYRNA 30080

PARKER, T. L. 1E ACT SL
DOUGLAS 31533

PARKHURST, ROBERT D. 56 ACT PD
107 WOODROW WILSON, VALDOSTA 31601

PARKS, JOSEPH W., JR. 2C ACT FP
P. O. BOX 609, NEWNAN 30263

PARMER, KEITH M. 14 ACT FP
CANTON MED. CTR., CANTON 30114

PARNELL, R. PARKS, JR. 2S ACT FP
OAKDALE CLINIC, SMYRNA 30080

PARRISH, JOE E. 1C ACT OBG
115 HOSPITAL DR., CARROLLTON 30117

PARRISH, ROBERT A., JR. 54 ACT SL
TALMADGE MEM. HOSP., AUGUSTA 30902

PARRISH, WILLIAM C. 13 ACT FP
160 N. MAIN ST., ALPHARETTA 30201

PARROTT, JESSE LYLE 56 ACT FP
HAHIRA 31632

PARSONS, RICHARD C. 22 ACT ALR
755 COLUMBIA DR., DECATUR 30030

PARUNGAO, R. L. 2S ACT SL
1235 SALEM GATEWAY, CONYERS 30207

PASCHAL, J. DEAN 23 ACT PD
910 N. JEFFERSON ST., ALBANY 31705

PASCUAL, RAFAEL R. 2 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31061

PASTORIUS, GEORGE J. 11 DEI ANES
3601 BULL ST., SAVANNAH 31405

PATRICK, E. V. 1C ACT I
CARROLLTON 30117

PATRICK, JOHN W. 6S ACT R
P.O. BOX 170, THOMASTON 30286

PATTERSON, GEORGE W. 5C ACT FP
CODGE CT. HOSP., EASTMAN 31023

PATTERSON, SCOTT 2S ACT P
B11 JUNIPER ST., N.E., ATLANTA 30308

PATTERSON, JOS. H. 2S ACT PD
1405 CLIFTON RD., N.E., ATLANTA 30333

PATTERSON, MCLEOD 47 ACT FP
1612 ELMWOOD DR., COLUMBUS 31906

PATTERSON, WM. C. 17 ACT SU
3903 S. COBB DR., SUITE 11D, SMYRNA 30080

PATTON, MAURICE G. 54 ACT PH
1D01 BAILIE DR., AUGUSTA 30902

PATTON, PAUL B. 6 ACT I
777 HEMLOCK ST., MACON 31204

PATTON, SAMUEL E. 6 ACT I
P. O. BOX 4605, MACON 31208

PATY, ROBERT M., JR. 4E DES SL
P. O. BOX 527, OXFORD 30267

PAULK, E. ALAN, JR. 2S ACT I
6 LAVISTA PERIMETER OFC. PK., TUCKER 30084

PAULK, J. R. 1S ACT CALR
P. O. BOX 370, MOULTRIE 31768

PAULLIN, WM. L., JR. 2S ACT I
35 COLLIER RD., N.W., ATLANTA 30309

PAULY, ROBERT P. 6C ACT SL
800 E. DOYLE ST., TOCCOA 30577

PAUSA, SERGIO G. 17 ACT SL
123 GORDON RD., MABLETON 30059

PAYNE, JOHN F. 65 ACT GR
21D W. HANSELL ST., THOMASVILLE 31792

PAYNE, NETTLETON S. 2S ACT N
1365 CLIFTON RD., NE, ATLANTA 30322

PAYNE, PAUL J. 17 ACT GR
652 CHURCH ST., MARIETTA 30060

PAYNE, PETER M. 2S ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

PAYNE, ROBERT A. 1S ACT L
195 KING AVE., ATHENS 30601

PAYNE, R. F. 54 ACT PH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

PAYNE, WOODROW W. 3C ACT L
SHRINE RD., BRUNSWICK 31520

PEACOCK, LAMAR B. 2S ACT I
47B PEACHTREE ST., N.E., ATLANTA 30308

PEACOCK, RAY LOWELL, JR. 34 ACT PD
274 ENOTA DR., N.E., GAINESVILLE 30501

PEACOCKE, IVAN L. 2S ACT PATH
35 LINDEN AVE., N. E., ATLANTA 30322

PEARCE, T. ELDER, JR. 2S ACT SL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

PEAVY, PATRICK W. 2S DE2 FP
4853 RIVER BASIN DR.,JACKSONVILLE,FL 32207

PEEK, STANLEY L., JR. 2S ACT SL
1935 POWELL MILL RD., N.W., ATLANTA 30318

PEIRCE, KENNETH E. 47 ACT AL
MEDICAL ARTS BLDG., COLUMBUS 31901

PELTZ, ROSEMONDE S. 22 ACT I
755 COLUMBIA DR., DECATUR 30030

PENA, LEOPOLD I. 17 ACT SL
3B12 AUSTELL RD., MARIETTA 30060

PENCE, ROBERT L. 8 ACT
P. O. BOX 388, METTER 30439

PENDERGRAST, WM. J. 29 ACT SL
478 PEACHTREE ST., N.E. ATLANTA 30308

PENDLEY, WALTER D. 27 ACT FP
1001 AVENUE C, ROME 30163

PENNINGTON, CLAUDE LEE 6 ACT ALR
800 FIRST STREET, MACON 31201

PENNINGTON, E. EARL 29 ACT SL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

PENNINGTON, JOHN A. 17 ACT ANES
3312 BUNKER HILL CR., MARIETTA 30062

PENTECOST, MARK P. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

PEPIN, HENRY S. 65 ACT FP
602 E. SEIXAS ST., THOMASVILLE 31792

PERDOMO, ROBERTO R. 2 ACT FP
STATE HOSP., MILLEDGEVILLE 31061

PERDUE, GARLAND D., JR. 29 ACT SL
EMORY UNIVERSITY CLINIC, ATLANTA 30322

PEREZ, A. R. 29 ACT SL
1311 CLEVELAND AVE., EAST POINT 30344

PERKINS, G. E., II 27 ACT PLL
HORSELEG ESTATES, ROME 30165

PERKINS, H. R. 54 DE1 CALR
P. O. BOX 3583, AUGUSTA 30904

PERKINS, JACK B. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

PERKINS, J. MORRIS 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

PERKINSON, NEIL G. 29 ACT SL
384 PEACHTREE ST., N. E., ATLANTA 30308

PER-LEE, JOHN H. 29 ACT ALR
EMORY UNIV. CLINIC, ATLANTA 30322

PERLING, DAVIS S. 29 ACT I
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341

PERROW, G. H. 14 ACT FP
JASPER 30143

PERRY, ROBERT E., JR. 30 ACT PATH
P. O. BOX 1333, BRUNSWICK 31521

PERRY, SAMUEL W. 29 DE5 PD
5675 PTREE-DNWOY RD., STE 502, ATL 30342

PERSALL, JOHN T. 54 ACT OBG
1507 ANTHONY RD., AUGUSTA 30904

PESKIN, HERMAN 54 ACT I
1134 CRUID PARK AVE., AUGUSTA 30904

PESSOLANO, L. C. 54 ACT FP
2307 MARVIN PLACE, AUGUSTA 30906

PESZCZYNSKI, MIECZYSLAW 29 ACT PM
80 BUTLER ST., S. E., ATLANTA 30303

PETERS, HANS J. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31904

PETERS, JAMES S. 56 ACT R
4513 CLUB CIR., N.E., ATLANTA 30319

PETERS, MARGARET P. 29 S ANES
1670 CLAIRMONT RD., N. E., ATLANTA 30329

PETERSON, T. A. 11 ACT FP
11 W. JONES ST., SAVANNAH 31401

PETRIE, LESTER M. 29 DE1 PH
304 WILTON DR., DECATUR 30030

PETTIT, MANSON B. 65 ACT P
PINETREE BLVD., THOMASVILLE 31792

PHELPS, PAUL R. 6 ACT SL
781 SPRINGS ST., MACON 31201

PHILLIPS, A. M., JR. 6 ACT OR
380 HOSPITAL CR., MACON 31201

PHILLIPS, ANDRO P. 11 ACT FP
323 EAST JONES STREET, SAVANNAH 31401

PHILLIPS, CHARLES D. 29 ACT CR
607 HOLCOMB BRIDGE RD., ROSWELL 30075

PHILLIPS, JAMES E. 6 ACT PATH
4946 BRITTANY DR., MACON 31204

PHILLIPS, JOE M., JR. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060

PHILLIPS, THOMAS W. 29 ACT R
25 PRESCOTT ST., ATLANTA 30308

PITTARD, M. D. 60 ACT FP
TOCCOA 30577

PITTMAN, CARL S. 66 DE5
TIFTON 31794

PITTMAN, CARL S., JR. 66 ACT FP
TIFTON 31794

PITTMAN, FRANK S., III 29 ACT P
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

PITTMAN, O. C. 37 ACT
COMMERCE 30529

PHELPS, PAUL R. 6 ACT SL
781 SPRING ST., MACON 31201

PLAUTH, WILLIAM F., JR. 29 ACT PDC
1365 CLIFTON RD., N.E., ATLANTA 30322

PLINKE, ROBERT W. 7 ACT FP
HWY 5, SOUTH, ELLIJAY 30540

POLIAKOFF, SAMUEL R. 29 ACT OBG
3312 PIEDMONT RD., N.E., ATLANTA 30305

POLITSOS, MICHAEL J. 29 ACT SL
35 LINDEN AVE., N.E., ATLANTA 30308

POLLARD, ZANE F. 29 ACT OPH
575 W. PTREE ST., NE, ATLANTA 30308

POLLOCK, CHARLES E. 7E ACT SL
WASHINGTON 30673

POLLOCK, JOHN EDWARD JR. 7E ACT FP
GORDON ST., WASHINGTON 30673

POMEROY, W. L. 72 OE5 SL
WAYCROSS 31501

POMEROY, WILLIAM L., JR. 72 ACT I
1921 ALICE ST., WAYCROSS 31501

PONCE DE LEON, A. I. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

POOL, LELAND L. 34 ACT ANES
HALL CO. HOSPITAL, GAINESVILLE 30501

POOL, WINFORD H., JR. 54 ACT R
TALMADGE MEM. HOSP., AUGUSTA 30902

POOLE, ROBERT NEIL 29 ACT PD
5675 PTREE-DUNWOODY RD. N.E. ATLANTA 30342

POOLE, SAMUEL O. 34 ACT I
710 BROAD ST., S.E., GAINESVILLE 30501

POPE, ROY JR. 70 ACT FP
CHICKAMAUGA 30707

PORTER, HARRY, JR. 17 ACT P
3188 ATLANTA RD., S.E., SMYRNA 30080

PORTER, JOHN E. 11 ACT FP
5105 PAULSEN ST., SAVANNAH 31405

PORTER, MAC W. 29 ACT FP
MEDICAL CENTER, COLUMBUS 31902

PORTH, EDNA S. 29 ACT FP
3130 MAPLE DR., N. E., ATLANTA 30305

PORTILLO, LORENZO A. DEL 2 ACT P
P.O. BOX 507, HARDWICK 31034

PORTMAN, H. J. 11 ACT PD
118 E. 34TH ST., SAVANNAH 31401

POTITONG, BANLU 69 ACT I
211 THURSTON AVE., THOMASTON 30286

POTITONG, PRATOOM 69 ACT PD
211 THURSTON AVE., THOMASTON 30286

POTTER, WILLIAM D. 46 ACT FP
P. O. BOX 333, CAMILLA 31730

POU, LEO H., JR. 29 ACT ANES
2760 FELTON DR., EAST POINT 30344

POUND, EDWIN C., JR. 29 ACT PL
35 COLLIER RD., N.W., ATLANTA 30309

POUND, WILLIAM E. 6 ACT FP
670 NEW STREET, MACON 31201

POWELL, BARBARA A. 54 ACT OBG
MEDICAL VILLAGE, AUGUSTA 30904

POWELL, F. C. 22 ACT I
3307 WILTSHIRE DR., AVONDALE ESTATES 30083

POWELL, JACK H., JR. 20 ACT SL
P.O. BOX 609, NEWNAN 30263

POWELL, JOHN E., JR. 10 ACT FP
VILLA RICA 30180

POWELL, MATTHEW J. G. 6 ACT FP
MEDICAL CENTER OF CENTRAL GA., MACON 31204

PHINIZY, JOHN 54 ACT I
3651 WHEELER RD., AUGUSTA 30904

PHINIZY, IRVINE 54 DE5 I
SOU. FINANCE BLDG., AUGUSTA 30902

PHRYDAS, IRENE A. 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

PIATT, EDWARD D. 11 ACT R
9 MEDICAL ARTS CTR., SAVANNAH 31405

PICKENS, JAMES C. 60 ACT OBG
800 E DOYLE ST., TOCCOA 30577

PIERCE, MART T. 30 ACT FP
P. O. BOX 1003, BRUNSWICK 31520

PIEROTTI, JULIUS V. 29 DE1 FP
2407 E. CLUB DR., N.E., ATLANTA 30319

PIKE, BENJAMIN L. 11 ACT I
32 MEDICAL ARTS CENTER, SAVANNAH 31405

PILCHER, B. LAMAR 36 ACT R
HOUSTON CT. HOSP., WARNER ROBINS 31093

PILCHER, JAMES M. 39 ACT I
211 E. 7TH ST., LOUISVILLE 30434

PINE, ROBERT F. 23 ACT P
308 THIRD AVE., ALBANY 31705

PINTO, ALBERT P. 29 ACT OBG
4637 ELLISBURG CR., N.E., ATLANTA 30341

PINSON, HARRY D. 54 ACT SL
1467 HARPER ST., AUGUSTA 30902

PIRKLE, CECIL H. 29 ACT SL
1311 CLEVELAND AVE., EAST POINT 30344

PIRKLE, QUENTIN 22 ACT SL
1313 CRESDEN CR., N. E., ATLANTA 30319

PIRKLE, T. N. 6 ACT R
P.O. BOX 1002, COROELE 31015

POWELL, RALPH W. 22 ACT SL
1365 CLIFTON RD., N. E., ATLANTA 30322

POWERS, LEANDER K. 11 ACT FP
29 E. JONES ST., SAVANNAH 31401

PRADA, OSCAR 42 ACT FP
112 ROWE ST., DUBLIN 31021

PRATHER, STUART F., JR. 54 ACT R
3623 J. DEWEY GRAY CIRCLE, AUGUSTA 30904

PRATER, R. BURT, JR. 22 ACT FP
4555 N. SHALLOWFORD RD., ATLANTA 30341

PREEDY, JOHN R. K. 29 ACT I
69 BUTLER ST., S.E., ATLANTA 30303

PRICE, NORMA A. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

PRICE, QUENTIN 42 ACT FP
205 W. GAINES ST., DUBLIN 31021

PRIETO, EDWARD A. 66 ACT ANES
702 W. 6TH ST., TIFTON 31794

PRIM, CARY J. 6 ACT ANES
1860 FLINTWOOD DR., MACON 31201

PRINCE, ALAN D. 17 ACT A
50 PLAZA WAY, MARIETTA 30060

PRINCE, RUSSELL B. 22 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

PRINTZ, DON W. 22 ACT D
4303 LAVISTA RD., TUCKER 30084

PRITCHETT, JOHN H., JR. 10 ACT
BREMEN 30110

PRITZKER, MARTIN S. 11 ACT D
P. O. BOX 13603, SAVANNAH 31406

PROCHNICKI, LOUIS J. 17 ACT OBG
3910 AUSTELL RD., AUSTELL 30001

PROCTOR, ROBERT F. 42 ACT I
VA CENTER, DUBLIN 31021

PRUCE, MARTA 29 ACT P
10 CARLTON DR., N.W., ATLANTA 30342

PRUETT, JAMES E. 22 ACT ALR
755 COLUMBIA CR., DECATUR 30030

PRYOR, CAROL G. 54 ACT OBG
1500 JOHNS RD., AUGUSTA 30904

PUGH, JAMES W. 29 ACT FP
461 KING ARNOLD ST., HAPEVILLE 30354

PULLIAM, MORRIS M. 48 OE2 FP
RT. 4, ELIZABETH ST., COVINGTON 30209

PUMPELLY, ROBERT A. 75 ACT FP
P. O. BOX 1097, JESUP 31545

PUND, EDGAR R. 54 DES PATH
ROUTE 4, SENECA, S.C. 29678

PURCELL, BILL 31 ACT FP
CALHOUN 30701

PURCELL, J. W., JR. 48 ACT FP
COVINGTON 30209

PURKS, W. WARREN, JR. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

PURSLEY, NORMAN B. 54 ACT
GA. TRAINING SCHOOL, GRACEWOOD 30812

Q

QUANTZ, NEWTON G., JR. 54 ACT OTO
2283 WRIGHTSBORO RD., AUGUSTA 30904

QUARTERMAN, KEITH A. JR. 29 ACT SL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

QUATTLEBAUM, J. K. 11 DES SL
3701 WATERS AVE., SAVANNAH 31401

QUATTLEBAUM, J. K., JR. 11 ACT SL
P.O. BOX 9787, SAVANNAH 31402

QUATTLEBAUM, ROBERT B. 56 ACT R
P. O. BOX 1727, VALDOSTA 31601

QUATTLEBAUM, ROBERT, JR. 11 ACT L
P. O. BOX 3456, SAVANNAH 31403

QUILALA, EMILIANO P. 16 ACT FP
409 ARROWHEAD BLVD., JONESBORO 30236

QUILLIAN, WILLARD E., III 54 ACT P
MED. COLLEGE OF GA., AUGUSTA 30902

QUINN, FRANCIS B., JR. 29 ACT CALR
144 PONCE DE LEON AVE., N.E., ATLANTA 30308

QUINONES, PEDRO P. 29 A
99 BUTLER ST., S.E., ATLANTA 30303

R

RAAEN, TOM O. 22 ACT PATH
DEKALB GENERAL HOSPITAL, DECATUR 30030

RABB, FORTE C. 34 ACT O
327 NORTHSIDE DR., N.W., GAINESVILLE 30501

RABB, J. L. 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701

RABUN, J. B. 11 ACT R
311 E. HALL STREET, SAVANNAH 31401

RAGAN, KENNETH C. 17 ACT P
84 LACY ST., MARIETTA 30060

RAIFORD, MORGAN B. 29 ACT CPH
705 JUNIPER ST., N. E., ATLANTA 30308

RAINES, JACK A. 47 ACT P
2000 16TH AVE., COLUMBUS 31901

RAITZ, ROBERT L. 76 ACT
BURLEYSON DR., DALTON 30720

RAMOS, FERNANDO Q. 76 ACT SL
120 WALNUT ST., CHATSWORTH 30705

RAMOS, HAROLD S. 29 ACT I
35 LINDEN AVE., N.E., ATLANTA 30308

RAMSEY, SPEIR N. 11 ACT GBG
19 MED. ARTS CENTER, SAV. 31405

RANO, EDGAR O. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

RANDALL, ALFRED F., JR. 17 ACT I
641 CHURCH ST., MARIETTA 30060

RANDALL, R. BEAUVAIS, JR. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30032

RANDLE, GERALD P. 70 ACT FP
#6, BLDG. 7, BENBOW F, OXFORD, MS 38655

RANDO, STEPHEN 6 ACT R
752 HEMLOCK ST., MACON 31201

RANDOLPH, R. F. 15 ACT SL
740 PRINCE AVE., ATHENS 30601

RANDOLPH, W. QUENTON 3 ACT FP
WINDER 30680

RANDOLPH, W. T. 3 DES FP
WINDER 30680

RANKIN, JOSEPH L. 29 ACT O
384 PEACHTREE ST., N. E., ATLANTA 30308

RANKINE, C. A. N. 29 ACT FP
1224 FERNWOOD CIR., ATLANTA 30319

RAO, P. S. 54 ACT PDC
MEDICAL COLLEGE OF GA., AUGUSTA 30902

RAO, R. N. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902

RAPER, HAL STUART 45 R
THE FOUNDATION, WARM SPRINGS 31830

RASCOE, E. MARSTON 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

RASMUSSEN, E. P. 29 ACT R
1968 PEACHTREE RD., N. W., ATLANTA 30309

RASMUSSEN, WARREN A. 30 ACT PH
P.O. BOX 1219, BRUNSWICK 31520

RAUCH, SAMUEL OEAN 34 ACT I
710 BROAD ST., GAINESVILLE 30501

RAUBER, ALBERT PAUL 22 ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322

RAVELO, HUMBERTO C. 2 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31061

RAWLINGS, JOE D. 65 ACT FP
918 S. BROAD ST., THOMASVILLE 31792

RAWLINGS, WILLIAM 74 ACT FP
524 SPARTA RD., SANDERSVILLE 31082

RAWLINS, GEORGE M. 13 ACT FP
NO CURRENT ADDRESS

RAWLS, LEWIS L. 6 DES FP
1107 SOUTHERN TRUST BLDG., MACON 31201

RAWLS, OTIS GREY 23 ACT SL
910 N. JEFFERSON, ALBANY 31705

RAWLS, WILLIAM J. 22 ACT I
755 COLUMBIA CR., DECATUR 30030

RAWSON, CLARENCE W., JR. 11 ACT GR
P. O. BOX 6156, SAVANNAH 31405

RAY, WALKER L. 22 ACT PD
4112 E. PONCE DELEON AVE., CLARKSTON 30021

RAYBOURNE, JACK E. 6 ACT ANES
2934 VICTORIA CIR., MACON 31201

RAYEL, PETER A. 29 ACT G
6500 VERNON WOODS DR., N.E., ATLANTA 30328

RAYLE, ALBERT A., JR. 29 ACT R
490 PEACHTREE ST., N. E., ATLANTA 30308

RAYNOR, LUTHER K., JR. 36 ACT OBG
507 N. HOUSTON RD., WARNER ROBINS 31093

RE, PETER K. 17 ACT N
50 PLAZA WAY, SUITE B, MARIETTA 30060

READ, BEN S. 29 ACT G
340 BLVD., N. E., ATLANTA 30312

READ, JOS. C. 29 DES SL
3970 VERMONT RD., N.E., ATLANTA 30319

READ, SILAS C., JR. 15 ACT DPH
957 BAXTER ST., ATHENS 30601

REOO, BRYAN L., JR. 29 ACT R
401 PEACHTREE ST., N.E., ATLANTA 30308

REOO, STEPHEN C. 29 DES PD
2760 FELTON DR., EAST POINT 30344

REOO, STEPHEN S. 29 ACT PD
2760 FELTON DR., EAST POINT 30344

REOFEARN, J. A. 23 DES I
527 BROAD AVE., ALBANY 31701

REDFEARN, JAMES A., JR. 76 ACT
MEMORIAL DRIVE, DALTON 30720

REOFIELD, RONALD L. 28 ACT SL
GIBSON ST., HARTWELL 30643

REED, EDGAR A. 29 S I
1670 CLAIRMONT RD., DECATUR 30033

REED, JOHN H., JR. 34 ACT OPH
112B VINE ST., N. E., GAINESVILLE 30501

REEVE, THOMAS E., JR. 10 ACT SL
CARROLLTON 30117

REEVES, J. LANE 11 ACT OPH
P. O. BOX 8905, SAVANNAH 31402

REEVES, MARTIN M. 29 ACT ANES
485 N. HARBOR DR., ATLANTA 30328

REEVES, NATHAN 54 ACT I
2264 WRIGHTSBORO RD., AUGUSTA 30904

REEVES, SEAB E. A. 42 ACT ANES
219 WAVERLY OR., DUBLIN 31021

REEVES, W. HARRISON 29 ACT I
478 PEACHTREE STREET, N. E., ATLANTA 30308

REGALADO, JACINTO 2 A FP
299 YOUNGBLOOD CIRCLE, MILLEDGEVILLE 31061

REHERT, GERALD M. 29 ACT OBG
490 PTREE ST., STE 132-B, ATLANTA 30308

REICH, GEORGE A. 29 S PH
PEACHTREE 7TH BLDG., ATLANTA 30323

REICH, ROBERT A. 22 ACT I
755 COLUMBIA CR., DECATUR 30030

REID, JAMES W. 65 ACT
THOMASVILLE 31792

REIO, RAYMOND J., JR. 10 ACT FP
P. O. BOX 325, TALLAPOOSA 30176

REIO, WM. A. 29 ACT SL
340 BOULEVARD, NE, ATLANTA 30312

REIFLER, R. M. 6 ACT D
729 PINE ST., MACON 31201

REILLY, ENOS J. 17 ACT OBG
513 CAMPBELL HILL, MARIETTA 30060

REISH, MARTIN L. 29 ACT PD
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341

REITH, PAUL L. 45 ACT CR
THE FOUNDATION, WARM SPRINGS 31830

REITT, J. PETER 29 ACT NS
100 COLONY SQUARE, ATLANTA 30361

RELEFORD, CHARLES C. 59 ACT
218 W. BROAD ST., GRIFFIN 30223

REMY, HENRY 22 ACT PD
798 RAYS RD., STONE MOUNTAIN 30083

RENTZ, TURNER W. 58 ACT FP
COLQUITT 31737

RETTERBUSH, W. C. 56 ACT SL
BOX 2313, VALDOSTA 31603

REVELL, WALTER J. 39 ACT
P.O. BOX 5, LOUISVILLE 30434

REY, CHARLES J., JR. 17 ACT SL
4399 AUSTELL RD., AUSTELL 30001

REY, ROBERTO 2 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31062

REYNAUD, L. F. 29 ACT PD
1278 GORDON ST. S. W., ATLANTA 30310

REYNAUD, VIRGINIA G. 29 ACT PD
1278 GORDON ST. S. W., ATLANTA 30310

REYNOLDS, G. THOMAS 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792

REYNOLDS, JAMES WILEY 26 ACT FP
P.O. BOX 549, ASHBURN 31714

REYNOLDS, JOHN D. III 54 ACT NS
1521 POPE AVE., AUGUSTA 30904

REYNOLDS, J. S. 29 ACT FP
553 MOBILE AVE., S.W., ATLANTA 30315

REYNOLDS, KENNETH H. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223

REYNOLDS, MILTON B., JR. 21 ACT FP
DONALSONVILLE CLINIC, DONALSONVILLE 31745

RHAME, DONALD W. 6 ACT SL
700 SPRING ST., MACON 31201

RHAME, MARLAN L. VAN 22 ACT P
755 COLUMBIA CR., DECATUR 30030

RHANGOS, WILLIAM C. 11 ACT CR
210 E. HALL ST., SAVANNAH 31401

RHEA, JAMES W. 47 A PD
ARAMCO, BOX 2438, DHAHRAN, SAUDI ARABIA

RHENEY, THEODORE B. 22 ACT FP
2701 N. DECATUR RD., DECATUR 30033

RHODE, CHARLES MARTIN 54 ACT SL
VA HOSPITAL, AUGUSTA 30904

RHODES, WM. H., JR. 49 ACT FP
100 SCOTT ST., UNION POINT 30669

RHYNE, WALTER P. 23 DES OALR
P. O. BOX 806, ALBANY 31702

RICE, GUY V. 3 R PH
3116 RANDOLPH RD., N.E., ATLANTA 30345

RICE, KEITH C. 29 DES SU
RT. 1, CLAYTON 30525

RICE, M. HOBSON 22 ACT CPH
542 CHURCH STREET, DECATUR 30030

RICE, SAMUEL T. 47 ACT U
1430 THIRD AVE., COLUMBUS 31901

RICH, CHARLES A. 2 ACT P
FSH BOX 132, CHATTAHOOCHEE FLA 32324

RICHARDS, CHARLES K. 27 ACT FP
FLOYD HOSP., ROME 30161

RICHARDSON, A. C., JR. 29 ACT OBG
710 PEACHTREE ST., N. E., ATLANTA 30308

RICHARDSON, CHAS. H. 6 DES SU
2749 CHEROKEE AVE., MACON 31204

RICHARDSON, C. H., JR. 6 ACT SU
724 HEMLOCK ST., MACON 31201

RICHARDSON, CHARLES R. 8 ACT OBG
P. O. BOX 1066, STATESBORO 30458

RICHARDSON, HOWARD D. 29 ACT NS
340 BOULEVARD, N.E., ATLANTA 30312

RICHARDSON, RUSSELL E. 34 ACT FP
HALL CO. HOSP., GAINESVILLE 30501

RICHARDSON, STERLING H. 29 ACT SU
478 PEACHTREE ST., N. E., ATLANTA 30308

RICHARDSON, R. C. 23 ACT CALR
400 4TH AVE., ALBANY 31705

RICHMAN, GARY O. 29 ACT CPH
3316 PIEDMONT RD., N. E., ATLANTA 30305

RICHMOND, LEA 29 ACT SU
6500 VERNON WOODS DR., ATLANTA 30328

RICKS, HENRY C., JR. 29 ACT P
415 E. PACES FERRY RD.,N.E., ATLANTA 30305

RICKS, ROBERT L. 29 ACT OBG
565 FAIR ST., S.W., ATLANTA 30314

RIDGWAY, ROBERT E. 28 ACT FP
ROYSTON 30662

RIDLEY, C. L., JR. 6 ACT SU
380 HOSPITAL DR., MACON 31201

RIDLEY, HARRY W. 29 DES FP
SEA ISLAND 31561

RIDLEY, JOHN F. 29 ACT G
35 COLLIER RD., N.W., ATLANTA 30309

RIGAS, LAMBROS C. 27 ACT CBG
206 HOSPITAL CIR., ROME 30161

RIESER, CHARLES 29 DES CPH
3777 PACES FERRY RD., N. W., ATLANTA 30327

RIESER, JOHN C. 29 ACT DPH
1365 CLIFTON RD., N.E., ATLANTA 30322

RIGAS, LAMBROS C. 27 ACT CBG
206 HOSPITAL CIR., ROME 30161

RILEY, WELLS 16 ACT FP
151 WEST MILL, JONESBORO 30236

RINKER, GEORGE E. 68 ACT PATH
CITY-COUNTY HOSP., LAGRANGE 30240

RINKER, J. ROBERT 54 ACT L
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

RIST, KARL H. 29 ACT R
2440 EDGEWATER DR. S. W., ATLANTA 30311

RITCHEY, STERLING J. 29 ACT GR
EMORY UNIV. CLINIC, ATLANTA 30322

RIVERS, SHIRLEY L. 29 A I
1925 MONROE DR., N.E., ATLANTA 30324

RIVERS, W. P., JR. 47 ACT PD
2520 WYNNTON RD., COLUMBUS 31906

RIVKIN, LAWRENCE M. 29 ACT TS
1220 PACES FOREST DR., N. W., ATL 30327

RIZO, MIGUEL A. 76 ACT P
1217 MEMORIAL DR., DALTON 30720

ROACH, GEORGE S., JR. 29 ACT ALR
144 PONCE DE LEON AVE. N.E., ATLANTA 30308

ROBBINS, FRANK T. 62 ACT FP
513 OGLETHORPE BLVD., HINESVILLE 31313

ROBBINS, ROBERT C. 17 ACT I
52 TOWER RD., N. W., MARIETTA 30062

ROBERSON, PHIL E. 23 ACT OBG
P. O. BOX 343, ALBANY 31702

ROBERTS, B. J. 33 A I
MED. DIR., DIST. 22, TOCCOA 30577

ROBERTS, DAVID B. 47 ACT OBG
2400 13TH ST., COLUMBUS 31906

ROBERTS, DON R., JR. 30 ACT GR
3010 HAMPTON AVE., BRUNSWICK 31520

ROBERTS, JOHN MANLEY 29 ACT OR
1938 PEACHTREE RD., N.W., ATLANTA 30309

ROBERTS, LUTHER J. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901

ROBERTS, RALPH D. 5 ACT FP
FITZGERALD 31750

ROBERTS, SAVA M. 61 ACT R
P. O. BOX 621, AMERICUS 31709

ROBERTS, STEWART R., JR. 17 A R
80 BUTLER ST., S.E., ATLANTA 30303

ROBERTSON, ALEX F. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902

ROBERTSON, MASON G. 11 ACT I
P. O. BOX 13160, SAVANNAH 31406

ROBINSON, ALBERT H. 29 A PH
3060 PHARR COURT, N.W., ATLANTA 30305

ROBINSON, A. CLARK 10 ACT FP
P. O. BOX 1116, DOUGLASVILLE 30134

ROBINSON, J. C. 10 ACT R
TANNER MEM. HOSP., CARROLLTON 30117

ROBINSON, J. L. 45 ACT
P.O. BOX 481, CARROLLTON 30117

ROBINSON, DAVID 11 A R
4745 FAIRFAX CR., SAVANNAH 31405

ROBINSON, JOE S. 6 ACT SU
655 FIRST ST., MACON 31201

ROBINSON, JOHN H., III 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709

ROBINSON, PAUL H. 29 ACT C
1365 CLIFTON RD., N. E., ATLANTA 30322

ROBINSON, RALPH L. 29 ACT PD
3158 MAPLE DR., N.E., ATLANTA 30305

ROBINSON, ROBERT S. 8 ACT FP
P. O. BOX 45, METTER 30439

ROBITSCHER, JONAS 29 ACT P
EMORY UNIV. LAW SCHOOL, ATLANTA 30322

ROCHE, WM. PATRICK, JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021

RODDENBERRY, HARVEY B. 6 ACT CBG
380 HOSPITAL CR. SUITE 100, MACON 31201

RODDENBERY, S. A. 47 ACT SU
213 DOCTORS BLDG., COLUMBUS 31901

RODRIGUEZ, A. P. 29 ACT U
340 BOULEVARD, N.E., ATLANTA 30312

RODRIGUEZ, FERNANDO 29 S I
P. O. BOX 33115, N. DECATUR 30033

RODRIGUEZ, HUMBERTO 56 ACT SU
P. O. BOX 2274, VALDOSTA 31601

RODRIQUEZ, J. I. 29 ACT I
3307 PRINCE GEORGE ST., EAST POINT 30344

ROGERS, A. A. 37 DES FP
COMMERCE 30529

ROGERS, A.A., JR. 37 ACT FP
COMMERCE 30529

ROGERS, CHARLES G. 29 ACT CBG
340 BOULEVARD, N.E., ATLANTA 30312

ROGERS, EDWARD A., JR. 19 ACT CBG
700 S. MAIN, MOULTRIE 31768

ROGERS, HARRISON L., JR. 29 ACT SU
1938 PEACHTREE RD., N. W., STE 601, ATL 30309

ROGERS, J. HARRY 29 DES SU
490 PEACHTREE ST., N.E., ATLANTA 30308

ROGERS, J. V., JR. 22 ACT R
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

ROGERS, JAMES W. 6 ACT EM
3055 GENERAL LEE RD., MACON 31204

ROGERS, T. E., JR. 6 ACT OBG
856 FIRST ST., MACON 31201

ROLLINGS, HARRY E. 11 ACT I
100 E. PARK AVE., SAVANNAH 31401

ROMINE, BENJAMIN W. 65 ACT FP
P.O. BOX 232, QUITMAN 31643

ROOF, JACK B., JR. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

ROOKER, DONALD W. 29 ACT CALR
1365 CLIFTON RD., N. E., ATLANTA 30322

ROONEY, DONALD R. 17 ACT R
70 TOWER RD., N.W., MARIETTA 30060

ROPER, C. J. 14 ACT SU
JASPER 30143

ROPER, E. A. 14 ACT FP
JASPER 30143

ROQUE, R. T. 11 ACT FP
SPRINGFIELD MED. PROF., SPRINGFIELD 31329

ROSE, A. MCKOY, JR. 17 ACT SU
1416 CHEROKEE ST., MARIETTA 30062

ROSE, CORDT E. 76 ACT ANES
110 CHINQUAPIN WAY, ATHENS 30601

ROSE, DANIEL W. 11 ACT CTC
17 MEDICAL ARTS CENTER, SAVANNAH 31405

ROSEN, BARRETT F. 76 DE2 OR
P. O. BOX 548, CALTON 30720

ROSEN, E. F. 11 ACT CALR
5 E. GORDON STREET, SAVANNAH 31401

ROSEN, RONALD 17 ACT U
1620 AUSTELL RD., AUSTELL 30001

ROSEN, SAMUEL F. 11 DES D
P.O. BOX 960, SAVANNAH BCH. 31328

ROSENBAUM, BARRY J. 29 ACT NE
1365 CLIFTON RC, NE, ATLANTA 30322

ROSENBERG, RAYMOND 22 ACT PD
11 LAVISTA PERIMETER OFC. PK., DEC 30084

ROSENGART, CARL L. 11 ACT N
P.O. BOX 6683, SAVANNAH 31405

ROSS, GRACE R. 27 ACT FP
P. O. BOX 846, SEA ISLAND 31561

ROSS, THOMAS L. 6 ACT I
944 NOTTINGHAM DR., MACON 31201

ROSSI, ALBERTO E. 29 ACT OBG
2744 FELTON DR., EAST POINT 30344

ROSSITER, FRANCIS P., JR. 11 ACT AL
5 MIDTOWN MEDICAL CENTER, SAVANNAH 31401

ROTHENBERG, MARVIN B. 29 ACT GR
6500 VERNON WOODS DR., N. E., ATL. 30328

ROTTERSMAN, WILLIAM 29 ACT P
3280 HOWELL MILL RD. N. W., ATLANTA 30327

ROUGHTON, RALPH E., JR. 29 ACT P
1175 PEACHTREE ST., N.E., ATLANTA 30309

ROULE, J. VICTOR 54 DE1 CALR
2251 CUMMING RD., AUGUSTA 30904

ROUNTREE, CLYDE B. 22 ACT P
755 COLUMBIA CR., DECATUR 30030

ROUTLEDGE, JAMES A. 27 ACT SU
310 W. SIXTH ST., ROME 30161

ROUTON, JAMES L. 29 ACT ANES
705 JUNIPER ST., N. E., ATLANTA 30308

ROWE, THOMAS S. 29 ACT CPH
478 PCTREE ST., NE, STE 820-A, ATL. 30308

ROWELL, ROGER R. 22 ACT CPH
542 CHURCH ST., DECATUR 30030

ROWLAND, DAVID M. 22 ACT U
755 COLUMBIA CR., DECATUR 30030

ROWLAND, J. ROY, JR. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021

ROWLEY, CHARLES M. 6 ACT N
755 ORANGE TERR., MACON 31201

ROZIER, C. H. 6 ACT ANES
5151 ZEBULON RD., MACON 31204

RUBENSTEIN, ARNOLD B. 29 ACT U
2788 BAYARD ST., EAST POINT 30344

RUBIN, JOSEPH W. 54 ACT TS
MCG, AUGUSTA 30902

RUCKER, J. T., JR. 54 ACT ANES
812 13TH ST., AUGUSTA 30901

RUDDER, FRED F. 29 DE5 SU
465 HILLSIDE DR., N. W., ATLANTA 30342

RUDER, ERNST M. 29 ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

RUDOLPH, STEPHEN J., JR. 18 ACT IND
702 N. GASKIN AVE., DOUGLAS 30533

RUMBLE, CHAS. T. 6 ACT PD
RT. 3, BOX 43, FORSYTH 31029

RUNDLE, T. J. 61 ACT OPH
P.O. BOX 1026, AMERICUS 31709

RUSCA, JOHN A. 29 ACT PL
1311 CLEVELAND AVE. N. E., ATLANTA 30344

RUSHIN, C. E. 29 DE5 SL
478 PEACHTREE STREET, NE, ATLANTA 30308

RUSSELL, ALEX P. 11 ACT PATH
MEMORIAL MEDICAL HOSP., SAV. 31405

RUSSELL, DAVID A. 29 ACT FP
340 BOULEVARD, N.E., ATLANTA 30312

RUSSELL, E. K. 29 ACT I
573 W. PTREE ST., N.E., ATLANTA 30308

RUSSELL, FREDERICK L. 76 A FP
P. O. BOX 564, DALTON 30720

RUSSELL, R. JAMES 29 ACT PL
3250 HOWELL MILL RD., N.W., ATLANTA 30327

RUSSELL, ROGER K. 18 ACT FP
P.O. BOX 779, PEARSON 31642

RUTLEDGE, BEN A. 29 DE1 OR
2348 ECHO CLIFF CT., N. E., ATLANTA 30345

S

SAFER, IRWIN H. 11 ACT P
515 E. 63 ST., SAVANNAH 31405

SAFFAN, B. O. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308

SAFWAT, MOHAMED 29 A SL
1501 CLAIRMONT RD., DECATUR 30030

SAIN, ROBERT L. 29 A SL
US NAVAL HOSP., CHERRY POINT, NC 28533

ST. LOUIS, JOSEPH A., JR. 29 ACT OPH
275 CARPENTER DR., ATLANTA 30328

SAKER, A. F. 29 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30341

SALAM, ATEF A. 29 ACT SL
69 BUTLER ST.,S.E., ATL. 30303

SALE, WALTER T. 29 ACT R
35 COLLIER RD., N.W., ATLANTA 30309

SALTER, PAUL P. III 29 A SU
3131 LAVENTURE DR., CHAMBLEE 30341

SALTER, W. L. 11 DE1 FP
8915-A OLD MONTGOMERY RD., SAV. 31406

SAMARA, DAVID J. 61 ACT L
1102 E. LAMAR ST., AMERICUS 31709

SAMMONS, EDWARD E. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322

SAMS, FERROL A., JR. 16 ACT FP
FAYETTEVILLE 30214

SAMS, FRANK H. 61 DE1 FP
REYNOLDS 31076

SAMS, FRANK H., JR. 61 ACT FP
BOX 536, REYNOLDS 31076

SAMS, HELEN F. 16 ACT
FAYETTEVILLE 30214

SAMS, J. R. 48 DE5
COVINGTON 30209

SAMS, WILLIAM C., JR. 5 ACT FP
OCILLA 31774

SAMSON, ANTONIO L. 1 ACT FP
306 W. MANN ST., GLENNVILLE 30427

SANCHEZ, ELIO S. 27 ACT I
BATTEY STATE HOSP., ROME 30161

SANCHEZ, FRANCISCO R. 70 ACT FP
LAFAYETTE MEDICAL CENTER, LAFAYETTE 30728

SANCHEZ-MORENO, H. L. 29 ACT CBG
2739 FELTON DR., EAST POINT 30344

SANDBERG, JOHN 17 ACT
KING-WILLIAMS BLDG., SMYRNA 30080

SANDERS, BEVERLY B., JR. 6 ACT D
700 SPRING ST., MACON 31201

SANDERS, C. VERNON 29 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

SANDERS, CONRAD W., JR. 54 ACT SU
MED. COLL OF GA., AUGUSTA 30902

SANDERS, DRAYTON M., II 76 ACT I
MEMORIAL DR., DALTON 30720

SANDERS, F. HUNT 36 ACT ANES
212 HOSPITAL DR., WARNER ROBINS 31093

SANDERS, FLOYD R. 22 ACT FP
603 CHURCH ST., DECATUR 30030

SANDERS, GERALD E. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060

SANDERS, J. LARRY 76 ACT OBG
1217 MEMORIAL DR., DALTON 30720

SANDERS, RUTH J. 54 ACT R
1021 15TH ST., AUGUSTA 30904

SANDERS, STEVEN L. 29 ACT SL
490 PEACHTREE ST., N. E., ATLANTA 30308

SANDISON, J. CALVIN 29 DE5 DR
P. O. BOX 56422, ATLANTA 30343

SANFORD, SHELTON P. 15 A I
NO CURRENT ADDRESS

SANKARAN, K. N. V. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709

SANTOS, TEODORO DE LOS 23 ACT PATH
P.O. BOX 1828, ALBANY 31702

SAPP, CLARENCE J. 27 ACT SL
200 E. 3RD ST., ROME 30161

SAPP, GERALD L. 66 ACT OR
P.O. BOX 1368, TIFTON 31794

SAPP, WILLIAM P., SR. 2 ACT P
981 HUNTER ST., N.W., ATLANTA 30314

SAPPINGTON, T. A. 69 ACT FP
612 W. GORDON ST., THOMASTON 30286

SATCHER, MILTON B., JR. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344

SATHE, ANAND J. 42 ACT OBG
105 VERNON ST., DUBLIN 31021

SAUNDERS, A. F. 56 DE5 CBG
P. O. BOX 2035, VALDOSTA 31603

SAUNDERS, ELWYN A. 54 ACT OR
MEDICAL COLLEGE OF GA., AUGUSTA 30902

SAVAGE, C. P. 61 DE5 FP
MONTEZUMA 31063

SARDIE, SOLOMON Y. 29 ACT SL
2788 BAYARD ST., EAST POINT 30344

SARGENT, CARLTON W. 29 A PH
618 PONCE DE LEON AVE., NE, ATLANTA 30308

SAWYER, HORACE K., JR. 22 ACT FP
2054 LAWRENCEVILLE HWY., DECATUR 30033

SAX, CHARLES E. 11 ACT CBG
120 E. 34TH STREET, SAVANNAH 31401

SAYE, WILLIAM B. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060

SCARBROUGH, ROGER W., JR. 11 ACT CBG
11706 MERCY BLVD., SAVANNAH 31406

SCARDINO, PETER L. 11 ACT L
P. O. BOX 3458, SAVANNAH 31403

SCHAEFER, W. B. 60 DE1 SL
930 18TH AVE. S., NAPLES, FLA 33940

SCHARF, FORREST L. 36 ACT PATH
P.O. BOX 1467, WARNER ROBINS 31093

SCHARFF, LOUIS, III 54 ACT PD
GRACEWOOD HOSPITAL, GRACEWOOD 30812

SCHATTEN, WM. E. 29 ACT PL
1938 PEACHTREE RD., N. W., ATLANTA 30309

SCHELLACK, J. K. 29 ACT SL
490 PEACHTREE ST., N.E., ATLANTA 30308

SCHERMERHORN, THOMAS J. 29 ACT OPH
705 JUNIPER ST., N. E., ATLANTA 30308

SCHILLER, HERBERT M. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31901

SCHILLING, ROBINSON W. JR 54 ACT OTO
2282 WRIGHTSBORO RD., AUGUSTA 30904

SCHIMMEL, WALTER A. 30 ACT FP
120 COLONIAL CR., ST. SIMONS ISLAND 31522

SCHLANT, ROBERT C. 29 ACT I
69 BUTLER ST., S. E., ATLANTA 30303

SCHLEY, FRANCIS B., JR. 47 ACT PD
303 11TH STREET, COLUMBUS 31901

SCHLEY, PHILIP T. 47 ACT L
DOCTORS BLDG., COLUMBUS 31901

SCHLEY, RICHARD L., JR. 11 ACT PD
5509 PAULSEN ST., SAVANNAH 31405

SCHLOSSBERG, MICHAEL 29 ACT CBG
2788 BAYARD ST., EAST POINT 30344

SCHLOTTMAN, GEORGE C. 6 ACT L
718 FIRST ST., MACON 31201

SCHMIDT, DON 27 ACT FP
P. O. BOX 368, CEDARTOWN 30125

SCHMIDT, F. K. 17 ACT L
823 CAMPBELL HILL ST., MARIETTA 30060

SCHMITT, ELBERT W., JR. 29 ACT CR
1365 CLIFTON RD., N. E., ATLANTA 30322

SAPP, PHILIP B. 76 ACT ER
HAMILTON MEM. HOSP., DALTON 30720

SCHNEIDERMAN, STEVEN M. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033

SCHNICK, JOHN C. 47 ACT FP
MEDICAL CENTER HOSP., COLUMBUS 31902

SCHOENBUCHER, ALBERT K. 29 A GBG
47 TRINITY AVE., S. W., ATLANTA 30334

SCHOFFSTALL, ROBERT D. 6 ACT SL
P. O. BOX 6000, MACON 31208

SCHREEDER, JOHN M. 22 ACT FP
3652 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341

SCHRODER, J. SPALDING 29 ACT I
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

SCHUESSLER, CARL C. 6 ACT CBG
380 HOSPITAL DR., MACON 31201

SCHUESSLER, GEORGE 47 ACT FP
302 DOCTORS BLDG., COLUMBUS 31901

SCHULZE, RICHARD R. 11 ACT OPH
728 E. 67TH ST., SAVANNAH 31405

SCHWARTZ, JAMES F. 29 ACT PD
69 BUTLER ST., S.E., ATLANTA 30303

SCHWARTZ, LARRY A. 6 ACT PD
376 ROGERS AVE., MACON 31204

SCHWARTZ, ROBERT I. 6 ACT PD
376 ROGERS AVE., MACON 31204

SCHWARTZ, SANFORD H. 29 ACT I
4536 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

SCHWARZMANN, STEPHEN W. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

SCOGGIN, W. A. 54 ACT OBG
TALMADGE MEM. HOSP., AUGUSTA 30902

SCOGGINS, HENRY D. 54 ACT CBG
1501 ANTHONY RD., AUGUSTA 30904

SCOGGINS, P. T. 37 DE5 FP
COMMERCE 30529

SCOTT, LEGH R. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

SCOTT, THOMAS P., JR. 29 ACT PD
1311 CLEVELAND AVE., EAST POINT 30344

SCOTT, WILBUR M. 2 ACT SL
230 JEFFERSON ST., MILLEDGEVILLE 31061

SEAGO, RICHARD W. 27 ACT SL
405 ALABAMA AVE., BREMEN 30110

SEALEY, ROMERO M. 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SEALY, HUGH K. 6 ACT I
765 SPRING ST., MACON 31201

SEARCY, ASHBURN P. 54 ACT ANES
P. O. BOX 2820, AUGUSTA 30904

SEARS, ROBERT A. 29 ACT NS
1175 PEACHTREE ST., N. E., ATLANTA 30361

SEAVEY, PAUL W. 2S ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

SEAY, E. FAXTON 3E ACT
BOX 208, FT. VALLEY 31030

SEESE, PERRY G. 22 ACT P
2258 NORTHLAKE PKWY., TUCKER 30084

SELF, STANLEY J. 27 ACT D
302 W. 6TH ST., ROME 30161

SELL, M. B., JR. 54 ACT P
MEDICAL COLLEGE OF GA., AUGUSTA 30902

SELLERS, SIDNEY L. 76 ACT GBG
P. O. BOX 113E, DALTON 30720

SELLERS, T. F. 2S DE5
STATE DEPT. OF PUB. HEALTH, ATLANTA 30334

SELMONOSKY, CARLOS A. 17 ACT TS
1678 MULKEY RD., AUSTELL 30001

SELTZER, STEPHEN C. 11 ACT I&R
1200 N. ELM ST., GREENSBORO, NC 27401

SELVEY, HENRY A. 2S ACT P
6363 ROSWELL RD., N.E., ATLANTA 30328

SENEVIRATNE, D. G. 47 ACT EM
710 CENTER ST., COLUMBUS 31902

SENG, BARRY S. 3E ACT FP
212 HOSP. DR., WARNER ROBINS 31093

SENNETT, CHARLIE O., JR. 27 ACT PATH
FLOYD HOSP., ROME 30161

SERBES, YILMAZ A. 2S ACT CR
5583 GORDON RD., MABLETON 30059

SERGENT, PAUL M. 14 ACT FP
200 MARIETTA ST., CANTON 30114

SERRANO, GABRIEL 11 ACT FP
6 MEDICAL ARTS, SAVANNAH 31405

SERRATO, J. C., JR. 47 ACT CR
DOCTORS BUILDING, COLUMBUS 31901

SESSIONS, GEORGE P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

SESSIONS, HOWARD K. 2S A PH
P. O. BOX 781, SUMNER 31789

SESSIONS, ROBERT T. 17 ACT SL
811 CHURCH ST., MARIETTA 30062

SETZER, EDWARD H. 6C ACT I
800 E. DOYLE ST., TOCCOA 30577

SEVERS, RONALD G. 3E ACT SL
DOCTORS CLINIC, WARNER ROBINS 31093

SEWELL, JESSE Q. 6 ACT FP
784 SPRING ST., MACON 31201

SEYMOUR, GLENN E. 23 ACT SL
412 FOURTH AVE., ALBANY 31705

SHACKELFORD, HUGH W. 2S ACT R
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SHACKLETT, ROBERT S. 6S ACT PATH
801 W. GORDON ST., THOMASTON 30286

SHAMA, ZOUTHEIR A. 2S ACT SL
2931 APPLING CR., CHAMBLEE 30341

SHANKS, JAMES Z. 2S ACT I
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

SHANTHA, TOTADA R. 2S ACT ANES
384 PEACHTREE ST., N.E., ATLANTA 30308

SHAPIRO, STANLEY T. 17 ACT GTC
2550 ATLANTA RD., SMYRNA 30080

SHARMA, KAILASH B. 54 ACT PATH
UNIV. HOSP., AUGUSTA 30902

SHARPLEY, F. F., JR. 11 DE5 PD
P. O. BOX 5054, SAVANNAH 31403

SHARPLEY, JOHN C. 11 ACT SL
1903 ABERCORN ST., SAVANNAH 31401

SHAVIN, JOEL S. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084

SHEA, P. C., JR. 2S ACT SL
25 PRESCOTT ST.,N.E., ATLANTA 30308

SHEAHAN, ROBERT C. 2S A AOM
1800 PEACHTREE ST., N.E., ATLANTA 30309

SHEALY, L. M. 6S ACT FP
P. O. BOX 631, QUITMAN 31643

SHEAROUSE, JOHN N. 2E ACT FP
DAVONIA 30553

SHEFFIELD, CHARLES RAY 53 ACT FP
JOHNSON STREET, DAWSON 31742

SHEHEE, WALTER H. 2S ACT P
1338 CLEVELAND AVE., EAST POINT 30344

SHEILS, ANDREW T., JR. 11 ACT CR
#7 ST. JOSEPHS PROF. PLAZA, SAVANNAH 31406

SHELOR, WILLIAM C., JR. 6 ACT L
718 FIRST ST., MACON 31201

SHELTON, THOMAS G. 47 ACT I
1952 NORTH AVE., COLUMBUS 31901

SHEPARD, DUNCAN 2S ACT SL
3312 PIEDMONT RD., N.E., ATLANTA 30305

SHEPARD, KIRK 6S DE1 SL
204 JURMIS ST., THOMASVILLE 31792

SHEPEARD, WALTER L. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902

SHEPHERD, EDWIN C. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405

SHEPHERD, MASON H. 54 ACT SL
1430 HARPER ST., AUGUSTA 30902

SHEPPECK, MICHAEL L. 11 ACT ADM
P.O. BOX 13607, SAVANNAH 31406

SHERMAN, ELDISE B. 11 ACT PATH
P. O. BOX 6542, STAT. C, SAVANNAH 31405

SHERMAN, HARRY C. 54 ACT SL
3010 SUSSEX DR., AUGUSTA 30909

SHERMAN, HENRY T. 5E ACT I
P.O. BOX 1409, VALDOSTA 31601

SHERRER, WEBSTER A. 17 ACT PATH
KENNESTONE HOSPITAL, MARIETTA 30061

SHESSEL, HERBERT L. 2S ACT GBG
340 BOULEVARD, NE, ATLANTA 30312

SHIELDS, JOSEPH D., III 6 ACT I
724 HEMLOCK ST., MACON 31201

SHIFLET, ROBERT E. 15 ACT L
1010 PRINCE AVE., ATHENS 30601

SHIH, CHEN-WEN 62 ACT GBG
P.O. BOX 406, HINESVILLE 31313

SHINALL, ROBERT P. 2S DE1 FP
927 ARTWOOD RD., N. E., ATLANTA 30307

SHIRLEY, JACOB L., JR. 23 ACT FP
411 S. MADISON ST., ALBANY 31701

SHIRLEY, WM. C. 6 ACT GBG
380 HOSP. DR., MACON 31201

SHIVER, CHARLES B. 54 ACT
806-13TH ST., AUGUSTA 30901

SHMERLING, SANFORD A. 2S ACT I
3316 PIEDMONT RD., N. E., ATLANTA 30305

SHORT, DWIGHT F., II 54 A SL
MED. COLL OF GA., AUGUSTA 30902

SHORTER, HENRY F., JR. 2S ACT FP
960 HUNTER ST., S.W., ATLANTA 30314

SHOTTS, RON F. 22 ACT GTC
1989 N. WILLIAMSBURG DR., DEC. 30033

SHUFORD, WADE H. 2S A R
80 BUTLER ST., S. E., ATLANTA 30303

SHULER, ROBERT K. 2S ACT PD
3158 MAPLE DR., N.E., ATLANTA 30305

SHULMAN, MICHAEL G. 2S ACT I
3200 HOWELL MILL RD., N.W. ATLANTA 30327

SHUMAN, ROBERT CHARLES 17 ACT ANES
LEWIS DRIVE, MARIETTA 30060

SHUMAN, IVY L., JR. 11 I&R
4604-G CORONADO DR., CHARLOTTE, NC 28212

SHUMAN, VILDA 72 ACT PD
WAYCROSS 31501

SIEGAL, JEROME H. 2S ACT I
1038 W. PEACHTREE ST., NW, ATL 30309

SIEVERT, ALAN J. 2S ACT PD
1100 CLEVELAND AVE., EAST POINT 30344

SIGAL, HOWARD MARVIN 17 ACT PD
1001 S. COBB DRIVE, SMYRNA 30080

SIGMAN, CHENEY C. 2S ACT AL
3393 PEACHTREE RD., N.E., ATLANTA 30326

SIGMAN, HOLLIS D. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

SIKES, ZACHARIAH S., JR. 6 ACT P
803 SPRING ST., MACON 31201

SILAN, J. RUBEN D. 62 ACT SL
P. O. BOX 406, FRASER DR.,HINESVILLE 31313

SILLER, EVERARD J. 2S ACT N
MONASTERY OF THE HOLY SPIRIT, CONYER 30207

SILVER, WILLIAM E. 22 ACT GTC
1770 OLD SPRNGHSE LN, N.E., CHAMBLEE 30341

SILVERMAN, BARRY D. 2S A C
1000 JOHNSON FRY. RD., NE, ATLANTA 30342

SILVERSTEIN, CHARLES M. 2S ACT R
3312 PIEDMONT RD., N. E., ATLANTA 30305

SIMMONS, JOHN W., III 22 ACT PD
4112 E.PONCE DE LEON AVE., CLARKSTON 30021

SIMMONS, MACK 3C ACT SL
338 MAJOR WRIGHT, SIMONS ISLAND 31522

SIMMONS, M. FREEMAN 22 ACT FP
301 WOODVIEW DR., DECATUR 30030

SIMMONS, ROBERT W. 76 ACT FP
114 MEMORIAL DR., DALTON 30720

SIMMONS, WILLIAM C. 2S ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

SIMMONS, WILLIAM G. 55 ACT FP
SYLVANIA 30467

SIMONE, GREGORY L. 2S A
80 BUTLER ST., SE, ATLANTA 30303

SIMONTON, FREC F. 7C DE5 FP
CHICKAMAUGA 30707

SIMONTON, KINSEY M. 2S ACT GTC
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SIMPSON, HARVEY L. 61 ACT SL
1102 LAMAR ST., AMERICUS 31709

SIMPSON, MARSHALL A. 47 ACT P
BRADLEY CTR., COLUMBUS 31901

SIMPSON, WALTER W. 47 ACT EM
MEDICAL CENTER, COLUMBUS 31901

SIMS, A. R. 53 ACT
RICHLAND 31825

SIMS, FAYETTE A., JR. 13 ACT
LAWRENCEVILLE 30245

SIMS, FRED E. 23 ACT ANES
107 S. JEFFERSON ST., ALBANY 31702

SIMS, JAMES A. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

SIMS, STEWART EUGENE 2S ACT SL
AT&T-100 EDGEWOOD AVE, RM. 1605, ATL 30302

SIMS, WILLIAM G. 47 ACT PL
SUITE 212, DRS. BLDG., COLUMBUS 31901

SINGER, ARTHUR G. 6C ACT R
TOCCOA 30577

SINGLETARY, ELIZABETH A. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

SINGLETON, C. K. 65 ACT
FIRST AVENUE, S. E., CAIRO 31728

SIZEMORE, JULIAN J., JR. 47 ACT PD
808 21ST ST., COLUMBUS 31904

SKANDALAKIS, JOHN E. 2S ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

SKARDASIS, GEORGE M. 2S ACT VS
25 PRESCOTT ST., N.E., ATLANTA 30308

SKEEL, DAVID A. 54 ACT L
MCG., AUGUSTA 30902

SKELTON, C. B. 3 ACT FP
WINDER 30680

SKELTON, MARVIN E. 11 ACT R
5223 PAULSEN ST., SAV. 31405

SKELTON, W. DOUGLAS 2S ACT P
47 TRINITY AVE., S.W., ATLANTA 30334

SKINNER, JAMES M. 5S ACT CBG
610 SOUTH EIGHTH STREET, GRIFFIN 30223

SKINNER, JOHN J., JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021

SKIPWORTH, GEORGE B. 47 ACT O
711 CENTER ST., COLUMBUS 31901

SKOBBA, JOSEPH S. 2S A P
2386 DELLWOOD DR., N.W., ATLANTA 30305

SKORAPA, MARY Z. 25 ACT PM
80 BUTLER ST., S. E., ATLANTA 30303

SKORAPA, VICTOR, JR. 25 S R
1670 CLAIRMONT RO., N. E., ATLANTA 30329

SLADE, HELEN B. 22 ACT PO
768 JUNIPER ST., N. E., ATLANTA 30308

SLADE, JOHN OER. 25 ACT I
768 JUNIPER ST., N. E., ATLANTA 30308

SLATE, ROBERT W. 60 ACT SL
800 E. DOYLE ST., TOCCOA 30577

SLOAN, HERBERT P. 76 ACT PATH
HAMILTON MEM. HOSP., DALTON 30720

SLOAN, W. P. 25 DE5 I
340 BLVD., N. E., ATLANTA 30312

SLOAN, W. P., JR. 25 ACT I
340 BLVD. N. E., ATLANTA 30312

SLUTSKY, MORTON 25 ACT PL
275 CARPENTER DR., N. W., ATLANTA 30328

SMAHA, T. G. 55 ACT G
600 SOUTH 8TH STREET, GRIFFIN 30223

SMILEY, DAVID T. 25 ACT ALR
3316 PIEDMONT RD., N.E., ATLANTA 30305

SMILEY, F. JONES 70 ACT CBG
219 FIRST ST., FT. OGLETHORPE 30742

SMISSON, HUGH F. 6 ACT NS
740 HEMLOCK ST., MACON 31201

SMITH, ARTHUR A. 25 ACT CBG
401 PEACHTREE ST., N.E., ATLANTA 30308

SMITH, CARL A. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405

SMITH, CARTER 25 DE5 I
35 COLLIER RD., N. W., ATLANTA 30305

SMITH, CARTER, JR. 25 ACT I
35 COLLIER RD., N.W., ATLANTA 30305

SMITH, C. C. 54 ACT O
1349 DRUID PARK AVENUE, AUGUSTA 30904

SMITH, C. MORGAN, JR. 5 ACT FP
MEDICAL ARTS BLDG., FITZGERALD 31750

SMITH, CHARLES M. 27 ACT FP
ROCKMART 30153

SMITH, CHAS. W. 25 ACT CBG
57 SIXTH ST., N. E., ATLANTA 30308

SMITH, DARIUS A. 17 ACT FP
MEDICAL BLDG., DALLAS 30132

SMITH, DON T. 66 ACT FP
1824 N. LEE ST., TIFTON 31794

SMITH, DOUGLAS 22 ACT DR
1405 CHURCH ST., DECATUR 30030

SMITH, DOUGLAS L. 54 I&R
MEDICAL COLLEGE OF GA., AUGUSTA 30904

SMITH, E. G., JR. 25 ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

SMITH, EDWARD H., JR. 54 ACT O
1021 15TH ST., AUGUSTA 30901

SMITH, F. A., JR. 64 ACT FP
MCRAE 31055

SMITH, FRANK Q. 56 ACT CBG
P. O. BOX 2748, VALDOSTA 31601

SMITH, FRED C. 56 ACT SL
DOCTORS BLDG., VALDOSTA 31603

SMITH, GARY L. 27 ACT FP
TRION 30753

SMITH, GEORGE BERTLING 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901

SMITH, H. M. 11 ACT FP
3 MEDICAL ARTS CENTER, SAVANNAH 31405

SMITH, H. W. 25 ACT OB
SWAINSBORO 30401

SMITH, HENRY BRIGGS 56 ACT ALR
DOCTORS BLDG., VALDOSTA 31603

SMITH, HERBERT D. 6 ACT P
127 N. MAIN ST., STATESBORO 30458

SMITH, HILTON E. 47 ACT FP
CROSS COUNTRY PL. OFC.PK., COLUMBUS 31907

SMITH, JAMES E. 6 A SL
777 HEMLOCK ST., MACON 31201

SMITH, JAMES F. 27 ACT I
7 PROFESSIONAL COURT, ROME 30161

SMITH, JAMES M. 45 ACT FP
MANCHESTER 31816

SMITH, J. DORSEY 6 ACT FP
MEDICAL ASSOC. OF METTER., METTER 30439

SMITH, J. GRAHAM 54 ACT O
MED. COLLEGE OF GA., AUGUSTA 30902

SMITH, J. GREGG 6 DE5 PH
160 INDIAN SPRINGS RD., FORSYTH 31029

SMITH, JOEL P., JR. 25 ACT CALR
573 W. PEACHTREE ST., N. E., ATLANTA 30308

SMITH, JOHN M., JR. 30 ACT I
P. O. BOX 1059, ST. SIMONS IS. 31522

SMITH, LEO 72 ACT CALR
BOX 778, WAYCROSS 31501

SMITH, LUCIUS S. 27 ACT R
FLOYD HOSPITAL, ROME 30162

SMITH, LUTHER J., II 47 ACT P
1953-7TH AVE., COLUMBUS 31901

SMITH, MALCOLM M. 42 ACT FP
SHAMROCK COURT APT., DUBLIN 31021

SMITH, MARTIN H. 34 ACT PD
274 ENOTA DR., N. E., GAINESVILLE 30501

SMITH, MILLEDGE GLENN 30 ACT FP
3012 SHRINE RD., BRUNSWICK 31520

SMITH, MIRIAM F. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033

SMITH, NAT E. 6 ACT I
MERCER UNIVERSITY, MACON 31201

SMITH, PATTON P. 6 ACT FP
235 MEDICAL COURT, FORSYTH 31029

SMITH, R. L. 50 ACT FP
COCHRAN 31014

SMITH, REUBEN J. 15 ACT CBG
740 PRINCE AVE., ATHENS 30601

SMITH, RICHARD A. 29 ACT NS
35 COLLIER RD., N.W., ATLANTA 30305

SMITH, RICHARD B. 29 ACT PD
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

SMITH, ROBERT B., III 29 ACT SU
1365 CLIFTON RD., N.E., ATLANTA 30322

SMITH, ROBERT C. 72 ACT R
P. O. BOX 938, WAYCROSS 31501

SMITH, R. LOUIE 54 ACT I
1514 ANTHONY RD., AUGUSTA 30904

STRESE, FRITZ W. 65 ACT FP
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

SMITH, ROBERT R. 68 ACT SU
828 PINEY WOODS DR., LAGRANGE 30240

SMITH, ROBERT W. 29 ACT I
478 PEACHTREE ST.,N.E., ATLANTA 30308

SMITH, ROBLEY O. 66 ACT FP
P. O. BOX 788, TIFTON 31794

SMITH, SAMUEL R. 17 ACT ANES
673 STEWART AVE., N. W., MARIETTA 30060

SMITH, STEPHEN O. 27 ACT PD
10 HORSELEG CREEK RD., ROME 30161

SMITH, STUART A. 27 ACT CTC
15 JOHN MADDOX DR., ROME 30161

SMITH, T. H. 56 DE5 CALR
3024 N. PATTERSON ST., VALDOSTA 31603

SMITH, THOS. H., JR. 56 ACT OPH
3024 N. PATTERSON ST., VALDOSTA 31601

SMITH, WM. A. 29 DE5 N
35 COLLIER RD., N.W., ATLANTA 30305

SMITH, WILLIAM A., JR. 25 ACT OPH
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SMITH, WILLIAM JACKSON 30 ACT ANES
GLYNN BRUNSWICK HOSPITAL, BRUNSWICK 31521

SMITH, W. P. 22 DE5 I
P.O. BOX 552, AVONDALE ESTATES 30002

SMITH, WILLIAM P., JR. 10 ACT SL
BOWDON 30108

SMITH, WILLIAM S. 25 ACT OTC
401 PEACHTREE ST., N.E., ATLANTA 30308

SMITH, W. T. 2 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31062

SMITH, WILLIAM V. 55 ACT CBG
503 S. 8TH ST., GRIFFIN 30223

SMOOT, RICHARD H. 22 RET SL
P.O. BOX 174, DECATUR 30030

SNEAD, JOSEPH A. 61 ACT CR
1102 E. LAMAR ST., AMERICUS 31709

SNELLING, W. R. 47 DE1 SL
2028 CELL DR., COLUMBUS 31906

SNITZER, JOSEPH A., III 25 ACT PD
3162 PIEDMONT RD., N. E., ATLANTA 30305

SNYDER, WILLARD A. 30 ACT
2700 PARKWOOD DR., BRUNSWICK 31520

SOOER, PARRY D. 25 ACT R
265 IVY ST., N. E., ATLANTA 30303

SOMERLOT, WARREN A. 17 ACT CBG
731 SANDTOWN RD., MARIETTA 30060

SOMERS, WM. H. 6 ACT R
P. O. BOX 6000 MACON 31208

SOMMERVILLE, MARGARET J. 2 ACT FP
90 W. WIEUCA RD., N.E., ATLANTA 30342

SONES, PETER J. 25 ACT R
1365 CLIFTON RD., N. E., ATLANTA 30322

SORACCO, GERARDO J. 25 ACT TS
1311 CLEVELAND AVE., EAST POINT 30344

SORIANO, MARIA J. R. 25 ACT PD
35 COLLIER RD., N.W., ATLANTA 30305

SORSOAHL, OLIVER A. 29 ACT R
300 BOULEVARD, NE, ATLANTA 30322

SOSBY, JOHN T. 20 ACT CBG
P. O. BOX 609, NEWNAN 30263

SOTUS, PETER C. 22 ACT SL
3606 CHAMBLEE-TUCKER RD., CHAMBLEE 30341

SOUMA, JOHN A. 6 S CBG
MARTIN ARMY HOSP., FT. BENNING 31906

SOUMA, MICKI C. 47 ACT CBG
P.O. BOX 951, COLUMBUS 31902

SOUTHER, JOE C. 3 ACT FP
802 E. BROAD ST., WINDER 30680

SOUZA, RENATO C. 16 ACT EM
274 SENOIA RD., FAIRBURN 30213

SOWELL, DAVID S. 25 ACT FP
2797 CAMPBELLTON RD., ATLANTA 30311

SOWELL, RAYMOND F., JR. 11 ACT P
615 ROSWELL RD., N.E., MARIETTA 30060

SPANIER, JACOB A. 25 ACT CBG
340 BOULEVARD, N.E., ATLANTA 30312

SPANJER, RAYMOND F. 27 ACT FP
P.O. BOX 846, SEA ISLAND 31561

SPEAR, J. LOUIS 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501

SPEARMAN, WILLIAM B. 25 ACT I
1201 PEACHTREE ST. ATLANTA 30361

SPEARS, ROBERT S. 54 ACT ANES
809 KAMEL CIRCLE, AUGUSTA 30904

SPEARS, WENTFORD A. 36 ACT CALR
212 HOSPITAL DR., WARNER ROBINS 31093

SPENCER, WM. C., III 25 ACT R
35 LINDEN AVE., ATLANTA 30308

SPERIOSU, S. D. 11 ACT P
1202 BRIGHTWOOD DR., SAVANNAH 31406

SPIER, EUGENE 25 ACT ANES
4195 GLEN DEVON DR., N.W., ATLANTA 30327

SPIVEY, HERMAN E. 27 ACT FP
COMMERCE ST., SUMMERVILLE 30747

SPIVEY, JAMES W. 36 ACT CR
124 HOSPITAL DR., WARNER ROBINS 31093

SPIVEY, OSCAR S. 6 ACT PD
2009 VINEVILLE AVE., MACON 31204

SPROUSE, JAMES F., JR. 17 ACT ANES
754 CHEROKEE ST., MARIETTA 30060

SPRUELL, WILLIAM H. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033

SREERAM, K. M. 6 ACT TS
700 SPRING ST., MACON 31201

STAATS, ETHAN F. 25 ACT CALR
35 COLLIER RD., N.W., ATLANTA 30309

STACY, L. DAVID 25 ACT PATH
1000 JOHNSON FERRY RD., N.E., ATL. 30342

STAHLKUPPE, ROBERT F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

STALEY, IRVING T. 17 ACT CPH
653 CHEROKEE ST., MARIETTA 30060

STAMBUK, ROBERT B. 6 ACT R
P. O. BOX 1048, STATESBORO 30458

STAMEY, CHARLES C. 47 ACT OBG
629 20TH ST., COLUMBUS 31906

STANCIL, MELODY ANN 17 ACT ANES
1805 ROSWELL RD., APT. 3-F, MARIETTA 30060

STAPLETON, GERALD M. 17 ACT OTO
2550 WINDY HILL ROAD, MARIETTA 30060

STAPLETON, JOHN L. 47 DES L
307 11TH ST., COLUMBUS 31901

STAPLETON, SIDNEY L., JR. 25 ACT VS
735 PIEDMONT AVE., N.E., ATLANTA 30308

STAPLETON, TOMMY K. 18 ACT FP
WESTSIDE DR., DOUGLAS 31533

STAPLETON, JAMES W. 42 S OR
VA HOSPITAL, DUBLIN 31021

STAR, FRANKLIN J. 47 ACT SL
905 CENTER ST., COLUMBUS 31901

STARLING, ROBERT L. 21 ACT FP
MOSELEY CLINIC, DONALSONVILLE 31745

STARR, DONALD C. 17 ACT R
KENNESTONE HOSP., RADIOLOGY, MARIETTA 30060

STARR, HARLAN M. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161

STATHAM, GEORGE W. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021

STATON, JEAN STEWART 22 ACT I
2754 N. DECATUR RD., DECATUR 30033

STATON, TED L. 25 ACT L
340 BOULEVARD, N.E., ATLANTA 30312

STEADMAN, HENRY E. 25 ACT SL
340 BOULEVARD, N. E., ATLANTA 30312

STEBLER, MICHAEL E. 72 ACT PATH
MEMORIAL HOSPITAL, WAYCROSS 31501

STECKER, DONALD C. 56 ACT
LOUIS SMITH MEM. HOSP., LAKELAND 31635

STEED, WILLIAM A. 54 ACT CALR
1122 DRUID PARK AVE., AUGUSTA 30904

STEELE, BYRON HAROLD 31 ACT FP
FAIRMOUNT 30139

STEGEMAN, JOHN F. 15 ACT I
1010 PRINCE AVE., ATHENS 30601

STEIN, IGNATIUS J. 25 ACT SL
2391 SEWELL RD., S. W., ATLANTA 30311

STEIN, J. D. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

STEINHAUER, JAMES J. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

STEINHAUS, JOHN E. 25 ACT ANES
1365 CLIFTON RD., N.E., ATLANTA 30322

STEPHENS, DAN B. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060

STEPHENS, MARVIN R. 76 ACT ANES
NO CURRENT ADDRESS

STEPHENS, ROBERT O. 17 ACT PD
680 CHURCH ST., MARIETTA 30060

STEPHENSON, CHAS. W. 70 DES FP
RINGGOLD 30736

STEPHENSON, ROBERT H. 25 ACT SL
3250 POWELL MILL RD., N.W., ATLANTA 30327

STERGUS, INGRID 27 RET PATH
BATTEY STATE HOSP., ROME 30161

STEVENS, EDWARD L. 6 ACT CALR
800 FIRST STREET, MACON 31201

STEVES, ELMA M. 22 ACT PD
3624 CHAMBLEE TUCKER RD., CHAMBLEE 30341

STEVES, SEVERO 22 ACT OBG
204 PIKE ST., LAWRENCEVILLE 30245

STEWART, CALVIN B. 25 DES SL
478 PEACHTREE ST., N. E., ATLANTA 30308

STEWART, CHARLES C. 21 ACT FP
P.O. BOX 371, DONALSONVILLE 31745

STEWART, CHARLES R. 47 ACT R
2747 CORA DR., COLUMBUS 31906

STEWART, DONALD M. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

STEWART, J. BENHAM 6 ACT SL
700 SPRING ST., MACON 31201

STILL, JOSEPH M., JR. 54 ACT PL
MCG, AUGUSTA 30902

STINCER, ELPIDIO F. 2 ACT P
STATE HOSP., MILLEDGEVILLE 31061

STIVERS, ROBERT R. 25 ACT PATH
50 COCA COLA PLACE, SE, ATLANTA 30303

STOCKS, S. ALLAN 54 ACT CPH
1514 ANTHONY RD., AUGUSTA 30904

STOCCARO, LELAND O. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902

STOKES, J. JACK 25 ACT CPH
478 PEACHTREE ST., N. E., ATLANTA 30308

STONE, ALBERT LAWRENCE 25 ACT PD
1035 MAIN STREET, FOREST PARK 30050

STONE, CHARLES F., JR. 25 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

STONE, H. HARLAN 25 ACT SL
1365 CLIFTON RD., N. E., ATLANTA 30322

STONE, JOHN R. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060

STONE, R. L. 11 ACT ANES
5737 COLONIAL DRIVE, SAVANNAH 31406

STONE, WILLIAM O. 25 ACT
573 W. PEACHTREE ST., N.E., ATLANTA 30303

STONER, CYRUS F. 25 DES CPH
340 BOULEVARD, N.E., ATLANTA 30312

STONER, W. P. 75 ACT FP
SYLVESTER 31791

STORY, FRANK C., JR. 54 ACT OBG
1505 WINTER ST., AUGUSTA 30904

STORY, JAMES L. 65 ACT SL
505 GORDON AVE., THOMASVILLE 31792

STOVALL, RUSSELL F., JR. 22 ACT CIC
755 COLUMBIA DR., DECATUR 30030

STRAIGHT, GEORGE W. 11 ACT SL
319 E. HALL STREET, SAVANNAH 31401

STRESE, FRITZ W. 65 ACT FP
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

STRETCHER, GEORGE S. 54 ACT D
MCG, AUGUSTA 30902

STRIBLING, WARREN DICKEY 34 ACT I
710 BROAD ST., S.E., GAINESVILLE 30501

STRICKLAND, AVERY W. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

STRICKLER, C. W., JR. 25 DE1 I
215 TOWNSEND PL., N.W., ATLANTA 30327

STRICKLER, D. T., JR. 10 ACT FP
P. O. BOX 518, DOUGLASVILLE 30134

STRITTMATTER, JAMES C. 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501

STROM, CARL H. 22 ACT PM
3300 MEMORIAL DR., DECATUR 30032

STRONG, WILLIAM B. 54 ACT PDC
MED. COLLEGE OF GA., AUGUSTA 30902

STROUP, DAVID C. 25 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30344

STUART, CARLOS A. 25 ACT I
1201 PEACHTREE ST., N.E., ATLANTA 30361

STUART, WILLIAM H. 25 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

STUBBS, JOE C. 56 ACT I
101 NORTHSIDE DR., VALDOSTA 31601

STUBBS, JOSEPH T., JR. 11 ACT CPH
720 E. 71ST ST., SAVANNAH 31405

STUBBS, O. WYTCH, JR. 22 ACT FP
3628 CHAMBLEE TUCKER RD., CHAMBLEE 30341

STUBBS, TRAWICK H. 22 ACT PH
47 TRINITY AVE., S.W., ATLANTA 30334

STUCK, ROBERT G. 76 ACT OR
MEMORIAL DR., DALTONEGA 30523

STUCKEY, ANN C. 55 ACT PD
317 1/2 S. HILL STREET, GRIFFIN 30223

STUCKEY, KATHERINE 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

STUMP, ROBERT L., JR. 56 ACT FP
1624 BOONE DR., VALDOSTA 31603

STURKIE, THOMAS OTIS 17 ACT CR
652 CHURCH ST., MARIETTA 30060

STURM, HIRAM MAXWELL 25 ACT D
401 PEACHTREE ST., N.E., ATLANTA 30308

SU, SHAW C. T. 11 ACT L
P.O. BOX 6555, SAVANNAH 31405

SUAREZ, RAYMOND 6 DES FP
844 PARKVIEW DR., MACON 31201

SUIT, JAMES I. 25 I&R CPH
80 BUTLER ST., S.E., ATLANTA 30303

SULLIVAN, CARY E. 25 ACT PD
2555 CUMBERLAND PKWY, ATLANTA 30339

SULLIVAN, DANIEL B. 54 ACT SL
30 HARPER ST., AUGUSTA 30902

SULLIVAN, JAMES H. 47 ACT L
1430 3RD. AVE., COLUMBUS 31902

SUMMEROUR, BROOKE F. 76 ACT ANES
P. O. BOX 252, DALTON 30720

SUMMERS, GERALD R. 54 ACT R
RT. 1, BOX 17C, THOMSON 30824

SUMMERS, ROLAND S. 11 ACT I
P.O. BOX 5086, SAVANNAH 31405

SUNG, YUNG-FONG 25 ACT ANES
EMORY UNIV. HOSP., DEPT. ANES., ATL 30322

SUSSMAN, HY C. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

SUTLIVE, WM. G. 11 ACT OBG
120 E. 34TH ST., SAVANNAH 31401

SUTTER, LUTHER O. 76 ACT FP
120 WALNUT, CHATSWORTH 30705

SUTTON, JAMES MACK, JR. 23 ACT PD
412 FOURTH AVE., ALBANY 31705

SWAIN, BRUCE 33 ACT FP
CLARKESVILLE 30523

SWANN, JULIAN W. 25 ACT D
490 PEACHTREE ST., N.E., ATLANTA 30308

SWANSON, HOMER 25 ACT NS
1938 PEACHTREE RD., N. W., ATLANTA 30309

SWEAT, MAXWELL J., JR. 23 ACT PD
1007-1ST AVE., ALBANY 31701

SWIFT, CHARLES RAY 70 ACT PATH
3827 RINGGOLD RD., CHATTANOOGA, TN. 37412

SWIFT, JONATHAN S. 17 ACT CR
1422 CHEROKEE STREET, MARIETTA 30062

SWIFT, THOMAS R. 54 ACT N
MCG, DEPT NEU., AUGUSTA 30902

SWILLING, EVELYN 6 ACT OB
844 PARKVIEW DR., MACON 31201

SWINGLE, ROGER L. 15 ACT CR
125 KING AVE., ATHENS 30601

SWINT, ROBERT F. 6 ACT SL
P. O. BOX 1088, STATESBORO 30458

SWISTERSKI, K. PETER 25 ACT ANES
20 LINDEN AVE., N.E., ATLANTA 30308

SYMBAS, PETER 25 ACT TS
69 BUTLER ST., S. E., ATLANTA 30303

SYN, WAI YUN 22 ACT I
2100 PARKLAKE DR., N. E., ATLANTA 30345

T

TABATABAI, JAFAR 17 ACT PATH
P.O. BOX 665, MABLETON 30059

TAIT, C. DOWNING, JR. 25 ACT P
820 DOUGLAS RD., N.E., ATLANTA 30342

TAKLE, LEIV M. 59 ACT GPH
646 S. 8TH ST., GRIFFIN 30223

TALBERT, WM. G., JR. 36 ACT FP
212 HOSPITAL DR., WARNER ROBINS 31093

TALBOTT, GEORGE D. 22 ACT I
500 WINN WAY, DECATUR 30030

TALLEDO, O. EDUARDO 54 ACT OBG
MED COLLEGE OF GA., AUGUSTA 30904

TALLEY, J. LECONTE, JR. 23 ACT CBG
901 N. MADISON ST., ALBANY 31705

TALLEY, ROBERT E. 47 ACT SL
DOCTORS BLDG., COLUMBUS 31901

TALMADGE, HARRY E. 15 ACT SL
489 N. MILLEDGE AVE., ATHENS 30601

TAMAYO, PEDRO L. 2 ACT GR
BOX 714, MILLEDGEVILLE 31061

TAN, HO T. 61 ACT ANES
AMERICUS & SUMTER CO HOSP., AMERICUS 31709

TANENBAUM, JULIAN B. 54 ACT PD
2315 CENTRAL AVE., AUGUSTA 30904

TANKESLEY, ROBERT M. 71 ACT R
437 PLANTATION DR., MONROE 30655

TANNER, DAVID E. 11 ACT R
P. O. BOX 6686, SAVANNAH 31405

TANNER, GEO. E. 42 ACT SL
606 ACADEMY AVE., DUBLIN 31021

TANNER, JACK E. 17 ACT CBG
1200 ROSWELL RD., MARIETTA 30060

TANNER, JAMES C., JR. 29 ACT SL
25 PRESCOTT ST., N.E., ATLANTA 30308

TANNER, MAURICE B. 65 ACT R
P.O. BOX 1001, THOMASVILLE 31792

TARANTO, MORRIS B. 29 ACT FP
727 W. PEACHTREE STREET, NE, ATLANTA 30308

TARCAN, YAVUZ A. 29 A I
80 BUTLER ST., S.E., ATLANTA 30303

TARRANT, GRACE L. 6 ACT R
MEDICAL CENTER, MACON 31201

TATE, JOHN DREWRY 27 ACT FP
MCCALL CLINIC, ROME 30162

TATUM, JOSEPH C. 22 ACT GR
755 COLUMBIA DR., DECATUR 30030

TATUM, L. L., JR. 59 ACT L
653 S. 8TH ST., GRIFFIN 30223

TAUBER, CHARLES P. 29 ACT P
415 E.PACES FERRY RD., N.E., ATLANTA 30305

TAYLOR, DAVID M. 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

TAYLOR, HOWARD P. 30 ACT FP
COTTAGE 218, SEA ISLAND 31561

TAYLOR, JAMES P. 65 ACT CBG
507 GORDON AVE., THOMASVILLE 31792

TAYLOR, JAMES W. 72 ACT CPH
P.O. BOX 778, WAYCROSS 31501

TAYLOR, JOHN EDWIN, JR. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021

TAYLOR, ROBERT P. 17 ACT CPH
MED. ARTS BLD., ROSWLL ST., MARIETTA 30060

TAYLOR, TERRY W. 29 ACT CPH
960 JOHNSON FERRY ROAD, N.E., ATL 30342

TAYLOR, THOMAS B. 10 ACT
DOUGLASVILLE 30134

TAYLOR, WARREN A. 65 ACT SL
PROF. BLDG. SIEXAS ST., THOMASVILLE 31792

TAYLOR, WILLIAM E. 74 ACT FP
SMITH ST., TENNILLE 31089

TAYLOR, WILLIAM J. 29 ACT FP
2049 PERKERSON RD., S. W., ATLANTA 30310

TAYLOR, WILLIAM M. 47 ACT R
MEDICAL CENTER, COLUMBUS 31902

TEAL, C. B., JR. 13 OE5 I
FALL CTY. HLTH DEPT., BOX 1295, GAIN 30501

TEATE, H. LUTEN, JR. 22 ACT PD
1901 CENTURY BLVD., N. E., ATLANTA 30345

TEEM, M. V. B. 17 ACT I
200 CHEROKEE STREET, MARIETTA 30060

TEEM, MARTIN V., JR. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060

TEH, JACK B. 76 ACT PATH
HAMILTON MEM. HOSP., DALTON 30720

TEKIN, MAHIR 29 ACT ANES
3240 JETT FERRY CT., N.E., DUNWOODY 30338

TEMPLES, POWELL M., JR. 29 OE4 P
209 EERIE AVE, DECATUR 30033

TENEBAUM, STANLEY M. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084

TEPLIS, PAUL 29 ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

TERRELL, JOE F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

TERRELL, WARREN 70 ACT FP
NO CURRENT ADDRESS

TERRY, JULES S. 29 A CBG
47 TRINITY AVE., ATLANTA 30334

TETHER, ROBERT S. 34 ACT SL
194 GOLD ST., N.E., GAINESVILLE 30501

THAGARD, ROY FRANK 30 ACT PD
2601 PARKWOOD DRIVE, BRUNSWICK 31520

THAMES, FRANK M., JR. 33 ACT FP
BOX 367, DEMOREST 30535

THEBAUT, BEN R. 29 ACT SL
1293 PEACHTREE ST., N.E., ATLANTA 30309

THEUS, THOMAS L. 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901

THIBODEAUX, DAVID C. 17 ACT R
70 TOWER RD., N.W., MARIETTA 30062

THIGPEN, CORBETT H. 54 ACT P
1423 HARPER ST., AUGUSTA 30902

THOMAS, DAVID R., JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

THOMAS, DONALD RAY 76 ACT FP
CLEVELAND ROAD, DALTON 30720

THOMAS, FRANK E. 23 OE1 PD
12 SHERWOOD RD. NW FT. WALTON BCH,FL 32548

THOMAS, KENNETH E. 29 ACT SL
1938 PEACHTREE RD., N. W., ATLANTA 30309

THOMAS, LUTHER M., JR. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904

THOMAS, R. P. 54 ACT DPH
1445 HARPER ST., AUGUSTA 30902

THOMAS, RUSSELL 61 OE1
131 SOUTH JACKSON STREET, AMERICUS 31709

THOMASON, W. L. 29 OE5 SL
1272 BREEZY LN., N.E., ATLANTA 30329

THOMASSON, GEORGE D. 15 ACT CH
P. O. BOX 8043, ATHENS 30601

THOMASSON, JAMES J., JR. 20 ACT SL
P.O. BOX 609, NEWNAN 30263

THOMPSON, CLEVELAND, JR. 9 OE1 FP
RT 2 BOX P-47 F, SANTEE, SC 29142

THOMPSON, CLEVELAND, III 72 ACT SL
410 ZACHRY ST., WAYCROSS 31501

THOMPSON, O. O. 29 OE5 FP
478 PEACHTREE ST., N.E., ATLANTA 30308

THOMPSON, E. F. 56 OE5 CALR
DOCTORS BUILDING, VALDOSTA 31603

THOMPSON, EMORY F. 56 ACT CALR
DOCTORS BUILDING, VALDOSTA 31603

THOMPSON, F. F. 61 ACT PATH
AMERICUS 31709

THOMPSON, HUGH S., JR. 29 ACT GR
1203 CLEVELAND AVE., EAST POINT 30344

THOMPSON, JOHN D. 29 ACT CBG
69 BUTLER ST., S.E. ATLANTA 30303

THOMPSON, JOHN W. 29 OE1 PD
3814 VERMONT RD., N.E., ATLANTA 30319

THOMPSON, JOSIAH 8 ACT SL
MCKINLEY & SMITH STS., CLAXTON 30417

THOMPSON, RAMON C. 15 ACT L
225 S. MILLEDGE, ATHENS 30601

THOMPSON, ROBERT E. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577

THOMPSON, ROBERT F. 29 ACT CALR
P.O. BOX 368, NEWNAN 30263

THOMPSON, WILBUR J. 34 ACT OBG
1144 VINE ST., N.E., GAINESVILLE 30501

THOMPSON, WILLIAM R. 29 ACT OBG
1691 CANDLER ROAD, DECATUR 30032

THOMPSON, WILLIAM R. 31 ACT
CALHOUN 30701

THORNTON, H. A. 49 ACT FP
P. O. BOX 326, GREENSBORO 30642

THORNTON, NANCY 54 ACT PD
VA HOSP., AUGUSTA 30904

THORNTON, NATHANIEL A. 29 ACT I
1201 PEACHTREE ST., N.E., ATLANTA 30361

THRASH, CALVIN L., JR. 47 ACT I
2039 WARM SPRINGS RD., COLUMBUS 31901

THRASHER, BARRIE H., JR. 29 ACT CPH
3280 HOWELL MILL RD.,NW,STE 207, ATL 30327

THREEFOOT, SAM A. 54 ACT I
VA HOSP., AUGUSTA 30904

THRELKELD, WILLIAM A. 56 ACT P
P. O. BOX 1727, VALDOSTA 31603

THRONE, MARTIN L. 29 ACT I
3648 CHAMBLEE-TUCKER RD., CHAMBLEE 30340

THURMOND, A. G. 54 ACT CBG
524 GEORGIA AVE., N. AUGUSTA, S. C. 29841

THURMOND, GEORGE W. 54 ACT CTC
2283 WRIGHTSBORO RD., AUGUSTA 30904

THURMOND, J. W. 54 OE5 OBG
1167 UNIVERSITY PL., AUGUSTA 30902

THWAITE, WALTER G. 29 A OBG
69 BUTLER ST., S.E., ATLANTA 30303

TIDMORE, THOMAS L., JR. 29 ACT ANES
1405 CLIFTON RD., N.E., ATLANTA 30322

TIDWELL, OWEN K. 68 ACT R
CITY-COUNTY HOSP., LA GRANGE 30240

TIDWELL, REX W. 6 ACT R
380 HOSP. DR., MACON 31201

TIFT, HENRY H. 6 ACT I
765 SPRING ST., MACON 31201

TILIACOS, JOHN N. 17 ACT GR
104 BEVERLY HILLS DR., MARIETTA 30062

TILLERY, WM. V., III 54 ACT CPH
1514 ANTHONY RD., AUGUSTA 30904

TILLINGER, ARNOLD J. 11 ACT P
515 E. 63RD ST., SAVANNAH 31405

TILLMAN, BILLUPS P. 15 ACT GR
125 KING AVE., ATHENS 30601

TILLMAN, RALPH A. 22 ACT OBG
3290 MEMORIAL DR., DECATUR 30032

TILLMAN, SAMUEL P. 8 ACT I
302 DONEHOO ST., STATESBORO 30458

TIMBERLAKE, G. B. 29 ACT SL
133 CARNEGIE WAY, N.W., ATLANTA 30303

TIMBERLAKE, LLOYD F. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

TINDALL, GEORGE T. 22 ACT N
1365 CLIFTON RD., ATLANTA 30322

TINDALL, HARRY C. 29 ACT CPH
1938 PEACHTREE RD., N.W., ATLANTA 30309

TINDALL, SUZIE C. 22 ACT N
DECATUR N. PROF. BLDG., DECATUR 30030

TIPPINS, WM. C., JR. 22 ACT CBG
5040 SNAPFINGER WOODS DR., DECATUR 30035

TIPTON, WILLIAM R. 76 ACT PD
MEMORIAL DR., DALTON 30720

TODD, CHARLES E., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

TODD, JOHN M. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904

TODINO, JOEL C. 27 ACT I
HARBIN CLINIC, ROME 30161

TOMAS, TEOFILO 29 ACT CPH
490 PEACHTREE ST., N.E., ATLANTA 30308

TOOLE, JAMES C. 17 ACT CBG
731 SANDTOWN RD., MARIETTA 30060

TOOLE, WM. NISBET 29 ACT L
6500 VERNON WOODS RD., N.E., ATLANTA 30328

TODTLE, GEORGE S. 13 ACT SL
DULUTH 30136

TOOTLE, JERRY C. 13 ACT SL
P.O. BOX 746, DULUTH 30136

TOPOROFF, STUART J. 29 ACT I
265 IVY ST., N.E., ATLANTA 30303

TORNOW, ABRAHAM M. 29 S GE
1670 CLAIRMONT RD., N. E., ATLANTA 30329

TORPIN, RICHARD 54 DE5 CBG
2618 WALTON WAY, AUGUSTA 30904

TORRES, SAMUEL A. 11 ACT L
P.O. BOX 6555, SAVANNAH 31406

TOVAR-DE-HOYOS, MANUEL 56 ACT FP
2311 N. PATTERSON ST., VALDOSTA 31601

TOWNSEND, ROBERT M. 17 ACT FP
627 CHEROKEE ST., MARIETTA 30060

TRACY, J. L., JR. 79 ACT FP
SYLVESTER 31791

TRAIN, JOHN KIRK, JR. 11 ACT ALR
1107 BULL ST., SAVANNAH 31401

TRAMBLIE, WILLIAM G. 56 ACT SL
116 HOSPITAL DR., LAKELAND 31635

TRAYLOR, JAMES BOTHWELL 15 ACT CBG
740 PRINCE AVE., ATHENS 30601

TRAYLOR, S. B. 59 ACT FP
BARNESVILLE 30204

TRENT, R. M. 22 ACT FP
2054 LAWRENCEVILLE HWY, DECATUR 30032

TREVEJO, WILLIAM A. 65 ACT ANES
1616 E. WASHINGTON ST., THOMASVILLE 31792

TRIANA, CARLOS R. 72 ACT SL
PATTERSON 31557

TRICE, JOHN C. 15 ACT P
150 TALMADGE DR., ATHENS 30601

TRIPPE, JUDSON R., JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060

TROTTER, JOHN F. 22 ACT FP
2054 LAWRENCEVILLE HIWAY., DECATUR 30033

TRULOCK, ALBERT S., JR. 23 ACT SL
800 N. JEFFERSON ST., ALBANY 31701

TRYON, WM. E. 17 ACT FP
2380 ROSWELL RD., MARIETTA 30062

TSAO, SHU-YUN T. 15 ACT PD
698 S. MILLEDGE AVE., ATHENS 30601

TSENG, GEORGE Y. 50 ACT PD
P. O. BOX 159, EASTMAN 31023

TUCK, ALBERT C., D.D.S. 65 AF
P.O. BOX 978, THOMASVILLE 31792

TUCK, G. G. 48 ACT FP
COVINGTON 30209

TUCKER, JOHN P. 19 ACT FP
300 13TH AVE., S.W., MOULTRIE 31768

TUCKER, R. P. 29 ACT SL
1603 WARE AVE., EAST POINT 30344

TUGGLE, M. VIRGINIA 22 ACT I
1336 COLUMBIA DR., DECATUR 30032

TUMLIN, WILLIAM D. 15 ACT FP
LEXINGTON 30648

TURCOTTE, MAURICE R. 47 ACT
P.O. BOX 786, COLUMBUS 31906

TURK, L. N., JR. 37 ACT SL
P. O. BOX 52, HOMER 30547

TURK, L. NEWTON, III 29 ACT TS
35 COLLIER RD., N.W., ATLANTA 30309

TURNER, AUGUST B. 29 ACT SL
384 PEACHTREE ST., N.E., ATLANTA 30308

TURNER, CORBETT H. 29 ACT P
EMORY UNIV. CLINIC, ATLANTA 30322

TURNER, DANIEL R. 22 ACT I
755 COLUMBIA DR., DECATUR 30030

TURNER, DAVID A. 23 ACT P
420 4TH ST., ALBANY 31705

TURNER, DON W. 22 ACT P
2905 PEACHTREE RD., N.E., ATLANTA 30305

TURNER, H. H. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

TURNER, J. R. 66 ACT
LAGRANGE 30240

TURNER, JOHN S., JR. 29 ACT CALR
1365 CLIFTON RD. N. E., ATLANTA 30322

TURNER, JOHN W. 29 DE5 SL
756 CYPRESS ST., N. E., ATLANTA 30308

TURNER, JOSEPH M. 66 ACT I
P. O. BOX 983, TIFTON 31794

TURRENTINE, PAUL E. 29 ACT CBG
35 COLLIER RD., N.W., ATLANTA 30309

TUTEN, CARROLL 30 ACT CPH
3011 KEMBLE AVE., BRUNSWICK 31520

TUTSCH, WILBERT R. 29 ACT CR
1311 CLEVELAND AVE., EAST POINT 30344

TUTTLE, ELBERT P., JR. 29 A I
69 BUTLER ST., S. E., ATLANTA 30303

TYLER, HERBERT D. 69 ACT I
612 W. GORDON ST., THOMASTON 30286

TYLER, RICHARD M. 29 ACT CR
2351 BOLTON RD., N.E., ATLANTA 30318

TYRONE, NELSON O., JR. 47 ACT L
DOCTORS BLDG., COLUMBUS 31901

U

UEHLING, EDWARD R. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033

UFEMA, JOHN W. 29 DE2 R
2666 PANGBORN RD., DECATUR 30033

UHL, LAWRENCE W. 29 ACT PD
6043 NAVAHO TR., MORROW 30260

ULLMAN, KARL H. 29 ACT I
1311 CLEVELAND AVE., EAST POINT 30344

ULLOA, A. N. 29 ACT I
2756 FELTON DR., EAST POINT 30344

UNDERWOOD, CHARLES R. 17 ACT
641 CHURCH ST., MARIETTA 30060

UNDERWOOD, FRANK O. 29 ACT R
1968 PEACHTREE RD., N.W., ATLANTA 30309

UPCHURCH, W. E. 29 DE5 L
98 CURRIER ST., N. E., ATLANTA 30308

UPSHAW, CHARLES B., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

UPSON, E. T. 29 S RET
RT. 7, BOX 241, CUMMING 30130

USHER, CHARLES JR. 11 ACT NS
6 E. LIBERTY ST., SAVANNAH 31401

UTLEY, HENRY G. 15 ACT CPH
759 COBB ST., ATHENS 30601

V

VALBUENA, D. A. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405

VALENTE, L. A. 30 ACT SL
1801 REYNOLDS STREET, BRUNSWICK 31520

VALENTINE, H. E., JR. 34 ACT I
429 SPRING ST., S. E., GAINESVILLE 30501

VAN BUREN, E. 29 DE5 I
768 JUNIPER ST., N. E., ATLANTA 30308

VAN BUREN, JAMES K. 29 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

VANDERBURGH, ALEXANDER 15 A FP
517 HAMPTON CT., ATHENS 30602

VANDERPOOL, GERALD E. 17 ACT AL
6500 VERNON WOODS DR., ATLANTA 30328

VANDERZALM, THEODORA 54 ACT R
VA HOSP., FOREST HILL DIV., AUGUSTA 30904

VAN OEVENTER, PHILLIP 23 ACT ANES
P.O. BOX 1828, ALBANY 31702

VAN DE WETERING, R. J. 29 ACT P
6500 VERNON WOODS DR., N.E., ATLANTA 30328

VANDIVER, RDY W. 22 ACT N
365 WINN WAY, DECATUR 30030

VAN DUYN, JOHN 47 ACT PL
DOCTORS BLDG., COLUMBUS 31901

VAN DYKE, PAUL B. 30 DE5 FP
P.O. DRAWER N, BRUNSWICK 31520

VAN GIESEN, GEO. E., JR. 54 ACT I
3623 OEWEY GRAY CIR., AUGUSTA 30909

VANSANT, CLAUCE V., SR. 10 DE5 FP
DOUGLASVILLE 30134

VANSANT, T. J., JR. 17 ACT I
P. O. BOX 1287, MARIETTA 30060

VARNER, JOHN B. 29 ACT CBG
490 PEACHTREE ST., N.E., ATLANTA 30308

VARNER, W. D. 47 ACT CBG
2300 MANCHESTER RD., COLUMBUS 31904

VASCONEZ, LUIS O. 29 ACT PL
1365 CLIFTON RD., ATLANTA 30322

VASKO, TRUMAN L. 26 ACT SL
P.O. BOX 247, VIENNA 31092

VASSEY, G. C. 70 ACT FP
791 CHICAMAUGA AVE., ROSSVILLE 30707

VAUGHAN, EDGAR ALLEN 17 ACT
74 MEDICAL SQUARE, MARIETTA 30060

VAUGHAN, R. H. 47 ACT SL
711 CENTER, COLUMBUS 31901

VAUGHAN, WILLIAM L. 44 ACT SL
KNOX PLAZA, THOMSON 30824

VEAL, CURTIS F. 2 ACT FP
P.O. BOX 489, MILLEDGEVILLE 31061

VEATCH, J. W., JR. 29 ACT SL
25 PRESCOTT ST., N.E., ATLANTA 30308

VELKOFF, ABRAHAM S. 29 ACT CBG
1175 PEACHTREE ST., N. E., ATLANTA 30309

VENABLE, JAMES HEISKELL 47 ACT CBG
204 MEDICAL ARTS BLDG., COLUMBUS 31901

VENABLE, JOHN H. 29 A PH
2300 MANCHESTER RD., COLUMBUS 31904

VENABLE, ROBERT N. 26 ACT FP
403 15TH AVE., CORDELE 31015

VERLEY, KARL W. 29 ACT CBG
2945 STONE HOGAN RD., S.W., ATLANTA 30331

VEVERKA, FRANK 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577

VICKERY, S. A. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529

VICTOR, IRVING 11 ACT L
P.O. BOX 6555, SAVANNAH 31406

VICTOR, JULES, JR. 11 ACT I
P. O. BOX 6336, SAVANNAH 31406

VICTOR, SAMUEL 72 ACT FP
1921 ALICE ST., WAYCROSS 31501

VIERA, MAX 42 S I
VA CENTER, DUBLIN 31021

VIGIL, RAMON A. 16 ACT ANES
33 SW UPPER RIVERDALE RD., RIVERDALE 30274

VIGRASS, HOWARD G. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

VILLANUEVA, L. S. 17 ACT P
1676 MULKEY RD., AUSTELL 30001

VINSON, FRANK 36 DE5 FP
FORT VALLEY 31030

VINSON, T. O. 22 ACT PH
440 WINN WAY, DECATUR 30030

VINTON, L. M., JR. 22 ACT FP
1043 LAKESHORE DR., AVONDALE ESTATES 30002

VIRUSKY, E. J. 1 ACT SL
N. MAIN ST., EXLEY 31513

VISINTINE, AAROLYN M. 29 A PD
69 BUTLER ST., S.E., ATLANTA 30303

VITNER, SAUL 29 ACT CBG
275 CARPENTER DR., N.E., ATLANTA 30328

VOGLER, WM. R. 22 ACT I
2057 CLAIRMONT RD., DECATUR 30033

VOHMAN, MANN DARIUS 29 ACT PATH
1968 PEACHTREE RD., N.W., ATLANTA 30309

VOLJAVEC, BOZIDAR F. 29 ACT FP
1311 CLEVELAND AVE., EAST POINT 30344

VOLPITTO, P. P. 54 ACT ANES
TALMADGE MEM. HOSP., AUGUSTA 30902

VON HAAM, EMMERICH, JR. 29 ACT GR
2788 BAYARD ST., EAST POINT 30344

VOYLES, WALTER R. 9 ACT SL
307 FOURTH ST., WAYNESBORO 30830

W

WADDELL, PEARL B. 30 R PD
1631 LAWTON LANE, LAKELAND, FLA 33803

WADE, LEO J. 49 ACT FP
208 VEASEY ST., UNION POINT 30669

WADE, JOHN S. 11 ACT SL
122 E. GASTON ST., SAVANNAH 31401

WADE, ROBERT C. 22 ACT
3371 COLUMBIA WOODS DR., DECATUR 30032

WADE, V. C. 56 ACT
104-C COUNTRY CLUB DR., AMERICUS 31709

WADSWORTH, GERALD E. 29 ACT CPH
478 PEACHTREE ST., N.E., ATLANTA 30308

WAGES, HARVEY S., JR. 76 ACT GBG
MEMORIAL DRIVE, DALTON 30720

WAGES, TOM L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518

WAGGONER, DAVID C. 29 ACT P
1970 CLIFF VALLEY WAY, NE, ATLANTA 30329

WAITS, EDWARD JONES 29 ACT SU
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

WAKEFIELD, JOHN R. 17 ACT
2404 MARIETTA RD., AUSTELL 30001

WALDEMAYER, E. W. 61 ACT FP
629 E. FORSYTH ST., AMERICUS 31709

WALDEN, CHARLES W. 22 ACT P
1989 N. WILLIAMSBURG DR., DECATUR 30033

WALDREP, JACK MARION 27 ACT U
101 JOHN MADDOX DR., ROME 30161

WALKER, C. J., JR. 34 ACT FP
242 ENOTA DR., N.E., GAINESVILLE 30501

WALKER, CHARLES O. 21 ACT SL
SEMINOLE MEM. HOSP., DONALSONVILLE 31745

WALKER, DUNCAN, JR. 6 ACT ALR
700 SPRING ST., MACON 31201

WALKER, GEO. L. 59 R
709 MAPLE DR., GRIFFIN 30223

WALKER, HENRY K. 29 A I
80 BUTLER ST., S.E., ATLANTA 30303

WALKER, JAMES A. 22 ACT L
755 COLUMBIA CR., DECATUR 30030

WALKER, JEROME M., JR. 22 ACT N
755 COLUMBIA CR., DECATUR 30030

WALKER, JOHN R. 29 DE5 SL
922 W. PTREE ST., ATLANTA 30309

WALKER, JOHN W. 22 ACT OBG
365 WINN WAY, DECATUR 30030

WALKER, KNOX, JR. 22 ACT OR
1405 CHURCH ST., DECATUR 30030

WALKER, LEO L., JR. 29 A I
2417 BERMUDA HILLS RD., COLUMBIA S.C 20204

WALKER, MOFFETT R., JR. 22 ACT I
BOX 3210, ATLANTA 30302

WALKER, OTTIS 76 ACT FP
CHATSWORTH 30705

WALKER, ROBERT J., JR. 6 ACT PH
770 HEMLOCK ST., MACON 31201

WALKER, W. W., III 22 ACT OBG
365 WINN WAY, DECATUR 30030

WALL, BITHEL 61 ACT L
1105 FETNER DR., AMERICUS 31709

WALLACE, BILL L. 17 ACT FP
2480 WINDY HILL RD., ATLANTA 30060

WALLACE, ROBERT G. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

WALLACE, RUSSELL W., JR. 22 ACT N
755 COLUMBIA CR., DECATUR 30030

WALLACE, STUART M. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403

WALLER, JAMES T. 11 ACT I
P. O. BOX 668E, STAT. C, SAVANNAH 31405

WALLER, ROBERT O. 23 ACT R
P.O. BOX 1924, ALBANY 31702

WALLER, ROY M., JR. 47 ACT FP
203 PHYSICIANS BLDG., COLUMBUS 31901

WALTER, AUSTIN J. 33 ACT FP
SAUTEE 30571

WALTER, JONNE B. 29 A I
300 BOULEVARD, N.E., ATLANTA 30312

WALTER, R. D. 31 ACT FP
CALHOUN 30701

WALTERS, GORDON E. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904

WALTON, KENNETH N. 29 ACT L
1365 CLIFTON RD., N.E., ATLANTA 30322

WALZ, PETER O. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033

WAMMOCK, HOKE 6E ACT SL
ENOCH CALLAWAY CANCER CLINICLAGRANGE 30240

WAMMOCK, VIRGENE S. 6E ACT O
771 LAKEWOOD DR., LA GRANGE 30240

WARD, CHARLES J. 22 ACT OBG
365 WINN WAY, DECATUR 30030

WARD, CHARLES M. 53 ACT FP
107 1/2 LEE STREET, DAWSON 31742

WARD, DANIEL F. 54 ACT P
1467 HARPER ST., AUGUSTA 30902

WARD, EUGENE L. 34 ACT CALR
P. O. BOX 13, GAINESVILLE 30501

WARD, JAMES 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901

WARD, JOHN ALBIN 29 S
1670 CLAIRMONT RD., N. E., ATLANTA 30329

WARD, M. CAROLYN 17 ACT OBG
805 CAMPBELL HILL ST., MARIETTA 30060

WARD, M. TERRY 29 ACT ER
1405 SHADOWOOD PKWY, NW., ATLANTA 30339

WARD, MARY C. 17 ACT PD
652 CHURCH ST., MARIETTA 30060

WARD, RICHARD S. 29 ACT P
EMORY UNIV., ATLANTA 30322

WARD, WM. C. 29 ACT SL
2292 FAIRBURN RD., S. W., ATLANTA 30331

WARD, WILLIAM T., JR. 22 ACT FP
231 E PONCE DE LEON AVE., 30030

WARKENTIN, JOHN 29 ACT P
2905 PEACHTREE RD., N.E., ATLANTA 30305

WARNER, CLINTON E. 29 ACT SL
319 W. LAKE AVE., N.W., ATLANTA 30318

WARNER, JOHN C., JR. 17 ACT PD
3001 S. COBB DR., S. E., SMYRNA 30080

WARNER, WM., PHILIP, JR. 29 ACT OR
35 COLLIER RD., N.W., ATLANTA 30309

WARNICK, LILLIAN P. 17 ACT PH
12 CAPITOL SQUARE, NE, ATLANTA 30334

WARNOCK, RALPH P. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

WARREN, CECIL D. 29 ACT
1143 BANBURY CROSS, AVONDALE ESTATES 30002

WARREN, HOWELL R. 29 ACT P
1970 CLIFF VALLEY WAY, NE, ATLANTA 30329

WARREN, W. C., JR. 29 DE5 ALR
490 PEACHTREE ST., N. E., ATLANTA 30308

WARREN, WALTER O. 29 ACT SL
1364 CLIFTON RD., N.E., ATLANTA 30322

WASDEN, HOWELL A. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

WASHBURN, LAWRENCE, JR. 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

WASSERMAN, STANLEY B. 29 ACT PD
1175 JOHNSON RD., N. W., ATLANTA 30318

WATERS, A. J. 54 ACT ANES
3405 SASANQUA DR., AUGUSTA 30904

WATERS, DONALD B. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

WATERS, JAMES L., JR. 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

WATERS, RAYMOND O. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161

WATERS, WM. C., III 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WATKINS, CHARLES B. 22 ACT FP
3543 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

WATKINS, JAMES W., JR. 29 ACT SL
623 PARK LN., DECATUR 30033

WATKINS, W. LORRAINE 22 ACT PD
69 BUTLER ST., S. E., ATLANTA 30303

WATKINS, W. M. 42 ACT SL
NO CURRENT ADDRESS

WATSON, DAVID T. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WATSON, DAVIS RONALD 47 ACT CALR
317 DOCTORS BLDG., COLUMBUS 31901

WATSON, EDWIN R. 6 ACT PD
745 PINE ST., MACON 31201

WATSON, FRANCIS M., JR. 29 DE2 OR
20 W. 64TH ST., 18-P, NY NY 10023

WATSON, JOHN C., JR. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

WATSON, W. G. 54 ACT OBG
1167 UNIVERSITY PL., AUGUSTA 30902

WATT, CHARLES H., JR. 65 ACT SU
900 GORDON AVE., THOMASVILLE 31792

WATT, WILLIAM VANCE 65 ACT SU
900 GORDON AVENUE, THOMASVILLE 31792

WATTERS, JULIAN Q. 29 ACT PD
5675 PTREE-DUNWOODY RD. N.E., ATL 30342

WATTS, JERALD L. 34 ACT OR
430 WASHINGTON ST., N.E. GAINESVILLE 30501

WAXLER, EDWARD B. 72 ACT I
P.O. BOX 899, WAYCROSS 31501

WEAVER, ALEXANDER H. S. 6 ACT CR
P. O. BOX 6317, MACON 31208

WEAVER, JERRY O. 27 ACT FP
502 N. MAIN ST., CEDARTOWN 30125

WEAVER, RICHARD J. 15 ACT PATH
ST. MARYS HOSP., ATHENS 30601

WEAVER, WILLIAM F. M. 6 ACT I
700 SPRING STREET, MACON 31201

WEAVER, WILLIAM T. 29 ACT TS
340 BOULEVARD, N. E., ATLANTA 30312

WEBB, RAY D. 11 ACT FP
SPRINGFIELD 31329

WEBBER, JOSEPH M. 47 ACT PATH
633-19TH ST., COLUMBUS 31901

WEBSTER, BRUCE S. 60 ACT EM
RT. 3, BOX 395-A, TOCCOA 30577

WEBSTER, PAUL D., III 54 ACT GE
MED. COLLEGE OF GEORGIA, AUGUSTA 30902

WEBSTER, ROBERT M. 29 ACT FP
2415 FAIRBURN RD., S.W., ATLANTA 30331

WEEKS, RICHARD B. 54 OE1 SL
4230 13TH ST., ST. SIMONS ISLAND 31522

WEEMS, H. E., JR. 36 ACT FP
PERRY 31069

WEENS, H. S. 29 ACT R
80 BUTLER ST., S. E., ATLANTA 30303

WEIHE, JAMES H. 54 I&R
MEDICAL COLLEGE OF GA., AUGUSTA 30902

WEINBERG, SEYMOUR PAUL 29 ACT OBG
384 PEACHTREE STREET, N. E., ATLANTA 30308

WEISMAN, EVAN B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060

WEISMAN, H. JAY 13 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

WEISS, EDWARD A. 30 ACT N
3010 HAMPTON AVE., BRUNSWICK 31520

WEISS, HARVEY A. 29 ACT PL
6500 VERNON WOODS DR., N.E., ATLANTA 30328

WEITZ, FRANK 29 ACT PD
401 PEACHTREE STREET, N.E., ATLANTA 30308

WELCH, ANDREW J. 29 A OR
300 BOULEVARD, N.E., ATLANTA 30312

WELLS, DAVID A. 76 ACT FP
1219 MEMORIAL DR., DALTON 30720

WELLS, JAMES M. 6 DE1 ANES
2983 VICTORIA DR., MACON 31201

WELLS, JOHN A. 6 ACT SU
724 HEMLOCK ST., MACON 31201

WELLS, JOHN G. 20 ACT I
P.O. BOX 1099, NEWNAN 30263

WELLS, ROBERT E. 29 ACT GR
1938 PEACHTREE RD., NW, ATLANTA 30309

WELLS, T. W., JR. 47 DE4 OPH
MARTIN ARMY HOSP., FT. BENNING 31905

WELTER, DONALD J. 54 ACT FP
1101 15TH ST., AUGUSTA 30901

WENGER, JULIUS 29 S I
1670 CLAIRMONT RD., N. E., ATLANTA 30329

WENGER, NANETTE K. 29 A
80 BUTLER ST. S. E., ATLANTA 30303

WERNER, JACQUELINE H. 16 ACT PATH
11 S.W. UPPER RVROALE RD., RVROALE 30274

WEST, J. HERBERT 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

WEST, JOHN H. 11 ACT I
P.O. BOX 13626, SAVANNAH 31406

WEST, JOHN T. 68 ACT SU
VERNON RD., LAGRANGE 30240

WEST, ROBERT M. 29 ACT
1134 MAIN ST., FOREST PARK 30050

WESTERFIELD, C. W. 11 ACT ANES
801 GOEBEL AVE., SAVANNAH 31404

WESTON, PAUL C. 54 ACT SL
1235 GWINNETT ST., AUGUSTA 30901

WETHERBY, DAVID 58 ACT
FT. GAINES 31751

WHALEY, MORGAN N. 44 ACT FP
NO CURRENT ADDRESS

WHALEY, WILLIAM H. 29 ACT
3250 HOWELL MILL RD., N.E., ATLANTA 30327

WHATLEY, E. C. 61 ACT
REYNOLDS 31076

WHATLEY, GEORGE S. 47 ACT GR
2009 WARM SPRINGS RD., COLUMBUS 31904

WHATLEY, LEWIS R. 4 DE1 FP
38 GREEN ST., CARTERSVILLE 30120

WHEELER, GEO. B., III 30 ACT OBG
3020 SHRINE RD., BRUNSWICK 31520

WHELAN, EDWARD J. 11 ACT U
2113 BULL STREET, SAVANNAH 31401

WHELCHEL, MERRITT C. 54 ACT CPH
905 15TH ST., SUITE E, AUGUSTA 30902

WHIDDEN, DESIDERIUS C. 29 ACT SL
490 PEACHTREE ST., ATLANTA 30308

WHIDDON, C. MAURICE 11 ACT SL
122 E. GASTON ST., SAVANNAH 31404

WHIPPLE, ROBERT L., JR. 29 ACT I
384 PEACHTREE ST., N. E., ATLANTA 30308

WHISNANT, CHARLES L., JR. 29 ACT I
1999 CLIFF VALLEY WAY, N.E., ATLANTA 30329

WHITAKER, CECIL F. 47 ACT OBG
629 20TH ST., COLUMBUS 31902

WHITAKER, WM. G., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

WHITE, HENRY C., JR. 6 ACT I
2009 VINEVILLE AVE., MACON 31204

WHITE, PERRY M. 29 ACT OR
340 BOULEVARD, N. E., ATLANTA 30312

WHITE, RONALD P. 29 ACT EM
340 BOULEVARD, N.E., ATLANTA 30312

WHITE, WILLIAM H., JR. 34 ACT OBG
1100 VINE ST., N.E., GAINESVILLE 30501

WHITE, WM. P. 22 ACT PD
558 MEDLOCK RD., DECATUR 30030

WHITECOTTEN, GLENN L. 11 ACT U
P.O. BOX 3458, SAVANNAH 31403

WHITEHEAD, C. MARK 68 ACT U
LAGRANGE 30240

WHITEHEAD, C. MARK, JR. 68 ACT U
303 SMITH ST., LAGRANGE 30240

WHITEHURST, JOHN O. 22 ACT SU
1365 CLIFTON RD., N.E., ATLANTA 30322

WHITESIDES, THOMAS E., JR. 29 ACT GR
EMORY UNIV. CLINIC, ATLANTA 30322

WHITFIELD, T. W. 76 ACT FP
1221 MEMORIAL DR., DALTON 30720

WHITNEY, DOUGLASS G. 29 ACT SU
353 PARKWAY DR., N.E., ATLANTA 30312

WHITSON, THEODORE C. 22 ACT PL
755 COLUMBIA DR., DECATUR 30030

WHITTLE, MICHAEL H. 57 DE4 FP
673 MED. DET., APO SAN FRANCISCO, CA 96332

WHITTLE, MICHAEL R. 18 ACT PATH
COFFEE GEN. HOSP., DOUGLAS 31533

WHITWORTH, JACK W. 45 ACT FP
1901 N. 2ND CT., LANETT, ALA. 36863

WHITWORTH, C. W. 34 ACT GALR
P. O. BOX 1159, GAINESVILLE 30501

WHYTE, H. JORDAN 29 ACT O
307 E. JOSEPHINE ST., SAN ANTONIO, TX 78206

WIEGAND, STEWART E. 29 ACT O
EMORY UNIVERSITY, ATLANTA 30322

WIENER, JERRY M. 29 ACT P
1075 W. CONWAY DR., ATLANTA 30327

WIGGINS, ROY A., JR. 29 ACT I
1938 PEACHTREE RD., N. W., ATLANTA 30309

WIGHT, ROBERT P. 66 ACT I
P. O. BOX 1186, TIFTON 31794

WILBER, JOSEPH A. 29 ACT
300 INTERSTATE N., ATLANTA 30327

WILBUR, OSCAR M., JR. 14 ACT PATH
302 W. MAIN ST., CARTERSVILLE 30120

WILCOX, C. R. 27 ACT OBG
10 HOSPITAL CIRCLE, ROME 30161

WILCOX, ROBERT B. 29 ACT L
490 PEACHTREE ST., N.E., ATLANTA 30308

WILDEY, ROY A. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405

WILDS, P. L. 54 ACT OBG
MEDICAL COLLEGE OF GA., AUGUSTA 30902

WILDSTEIN, GILBERT 29 ACT TS
490 PEACHTREE ST., N. E., ATLANTA 30308

WILHELM, CHARLES C. 17 ACT I
792 CHURCH ST. EXT., MARIETTA 30060

WILHELM, JOHN A. 29 A FP
275 FIFTH ST., N.W., ATLANTA 30318

WILKERSON, BERNIE J., JR. 22 ACT FP
2508 CARROLL AVE., CHAMBLEE 30341

WILKES, LESLIE L. 11 ACT GR
44 MEDICAL ARTS, SAVANNAH 31405

WILKES, W. A. 54 ACT PD
1203 HIGHLAND AVE., AUGUSTA 30904

WILKIEMEYER, RALPH M. 29 ACT L
3250 HOWELL MILL RD., ATLANTA 30327

WILKINS, JOHN M. 15 ACT ANES
1077 BAXTER ST., ATHENS 30601

WILKINS, S. A., JR. 29 ACT SL
EMORY UNIV. CLINIC, ATLANTA 30322

WILLEY, LOY W. 29 ACT OPH
1275 CLEVELAND AVE., EAST POINT 30344

WILLIAMS, A. F. 11 ACT I
423 BULL ST., SAVANNAH 31401

WILLIAMS, C. J. 11 ACT I
P. O. BOX 6167, SAVANNAH 31405

WILLIAMS, CHARLES ROY 39 ACT FP
WADLEY 30477

WILLIAMS, DAVID C., SR. 6 DE5 P
1142 GRUID PARK AVE., AUGUSTA 30904

WILLIAMS, DAVID C., JR. 54 ACT U
1142 GRUID PARK, AUGUSTA 30904

WILLIAMS, DONALD D. 6 ACT EM
1261 TWIN PINES DR., MACON 31201

WILLIAMS, GEO. A. 29 DE5 OBG
710 PEACHTREE ST., N.E., ATLANTA 30308

WILLIAMS, G FRASER 29 ACT OBG
2945 STONE HOGAN RD., CON. S.W., ATL 30331

WILLIAMS, GEORGE P. 54 ACT OBG
1505 WINTER ST., AUGUSTA 30904

WILLIAMS, H. J., JR. 6 ACT PD
1624 COLEMAN AVENUE, MACON 31201

WILLIAMS, JAMES D. 22 ACT PD
4511 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

WILLIAMS, JACK B. 54 ACT ANES
812 13TH ST., AUGUSTA 30901

WILLIAMS, JOHN L. 54 ACT NS
1521 POPE AVE., AUGUSTA 30904

WILLIAMS, JOHN W., JR. 28 ACT FP
LAVONIA 30553

WILLIAMS, JOSEPH P., JR. 29 A NS
NO CURRENT ADDRESS

WILLIAMS, MALCOLM H. 17 ACT I
3001 S. COBB DR., SMYRNA 30080

WILLIAMS, P. L., JR. 26 ACT FP
CORDELE 31015

WILLIAMS, RALPH CHESTER 29 A PH
2573 BIRCHWOOD DR., N.E., ATLANTA 30305

WILLIAMS, THEODORE G. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701

WILLIAMS, THOMAS H. 6 ACT SU
781 SPRING ST., MACON 31201

WILLIAMS, VIRGIL B. 59 ACT SL
571 SOUTH 9TH STREET, GRIFFIN 30223

WILLIAMS, WM. A., JR. 6 ACT FP
5297 BRANDYWINE DR., MACON 31204

WILLIAMS, WILLIAM TALBERT 17 ACT
705 CONCORD RD., SMYRNA 30080

WILLINGHAM, ROBT. T., JR. 29 ACT
35 COLLIER RD., N.W., ATLANTA 30309

WILLIS, LEO W. 21 ACT FP
P.O. BOX 915, BAINBRIDGE 31717

WILLIS, TOM V., JR. 30 ACT SL
2601 PARKWOOD DR., BRUNSWICK 31520

WILLOUGHBY, DAN H. 11 ACT I
2 MIDTOWN MEDICAL CENTER, SAVANNAH 31401

WILLS, BENJAMIN C. 11 ACT PA
835 E. 65TH ST., SAVANNAH 31405

WILLS, C. E., JR. 78 ACT FP
WASHINGTON 30673

WILLS, S. ANGIER 22 ACT SL
755 COLUMBIA DR., DECATUR 30030

WILLS, WILLIAM R., JR. 18 ACT FP
SHIRLEY AVE., DOLGLAS 31533

WILMER, JOHN GRANT 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WILSON, C. A., JR. 30 ACT FP
P.O. BOX 1518, BRUNSWICK 31520

WILSON, COLON H., JR. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

WILSON, FRANK A., III 61 ACT I
LESLIE 31764

WILSON, FRANK L., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

WILSON, HENRY H. 22 ACT PD
1510 OAK GROVE RD., DECATUR 30033

WILSON, JOHN P. 29 ACT SL
315 BOULEVARD, N.E., ATLANTA 30312

WILSON, J. S. 29 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

WILSON, LOUIS A. 29 ACT OPH
NO CURRENT ADDRESS

WILSON, OHLEN RUDOLPH 72 ACT
ALMA 31510

WILSON, RICHARD 29 DE5 N
47 INTERLOCHEN DR., N. E., ATLANTA 30305

WILSON, ROY G. 11 ACT PL
5105 PAULSEN ST., SAVANNAH 31405

WILSON, W. D. 11 ACT SL
111 E. JONES ST., SAVANNAH 31401

WINBURN, JAMES R., JR. 11 ACT SL
40 MED. ARTS BLDG., SAVANNAH 31405

WINDHAM, ADDIS D., SR. 33 ACT FP
BOX 367, DEMOREST 30535

WINE, MERVIN B. 65 ACT AL
THOMASVILLE 31792

WINNER, JONATHAN D. 29 ACT PD
6500 VERNON WOODS DR., N.E., ATLANTA 30328

WINSTON, R. K. 56 ACT DPH
DOCTORS BLDG., VALDOSTA 31603

WINTRUP, CHARLES K. 76 ACT EM
HAMILTON MEM. HOSP., DALTON 30720

WIRTH, FREMONT P. 11 ACT N
22 MEDICAL ARTS CENTER, SAVANNAH 31405

WITHAM, A. CALHOUN 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

WITHERINGTON, ROY 54 ACT U
MED COLLEGE OF GA., AUGUSTA 30902

WITHINGTON, JOHN C. 11 ACT I
1801 ABERCORN ST., SAVANNAH 31401

WOFFORD, BENJAMIN H., JR. 17 ACT PL
644 CHEROKEE ST., MARIETTA 30060

WOFFORD, JOHN B. 76 ACT ER
1217 MEMORIAL DR., DALTON 30720

WOHLGEMUTH, STEPHEN A. 29 ACT I
41 NELSON ST., BARTOW MED. CLN., CTV 30120

WOLFE, DAVID M. 23 A PH
P. O. BOX 273, LEESBURG 31763

WOLFE, WILLIAM W., JR. 11 ACT P
515 E. 63RD ST., SAVANNAH 31405

WOLFF, BERNARD P. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WOLFF, JOHN MCD. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WOLFF, LUTHER H. 47 ACT SL
MEDICAL ARTS BLDG., COLUMBUS 31901

WOLFF, WM. A. 47 ACT SL
MEDICAL ARTS BLDG., COLUMBUS 31901

WOLFMAN, RICHARD M. 29 ACT R
1000 JOHNSON FERRY RD., N.E., ATL 30342

WOMBLE, J. G. 54 ACT SL
1256 MERRY ST., AUGUSTA 30904

WOOD, CLAYTON E. 23 ACT D
1009 N. MONROE, ALBANY 31701

WOOD, D. LLOYD 76 DE5 FP
200 1/2 KING STREET, DALTON 30720

WOOD, HOMER P. 58 ACT FP
CLAY COUNTY HOSPITAL, FORT GAINES 31751

WOOD, MARCELLA D. 29 DE3 PD
3764 BRIARCLIFF RD., N.E., ATLANTA 30345

WOOD, R. HUGH 29 DE5 I
923 CASTLE FALLS DR., N. E., ATLANTA 30329

WOOD, ROBERT W., JR. 29 ACT OR
1938 PEACHTREE RD., N.W., ATLANTA 30309

WOOD, WILLIAM A., JR. 29 ACT I
33 PONCE DE LEON AVE. N.E., ATLANTA 30308

WOODALL, JAMES A. 69 ACT
316 W. GORDON ST., THOMASTON 30286

WOODALL, WM. PRUITT 69 ACT
316 W. GORDON ST., THOMASTON 30286

WOODARD, JOHN R. 29 ACT U
1365 CLIFTON RD., N.E., ATLANTA 30322

WOODARD, OTIS J., JR. 23 ACT P
420-4TH ST., ALBANY 31705

WOODHALL, J. P. 6 ACT SL
724 HEMLOCK ST., MACON 31201

WOODCS, E. ASHBY 21 ACT FP
BAINBRIDGE 31717

WOODSIDES, KENNETH T. 29 ACT IND
620 PEACHTREE ST., N.E., ATLANTA 30308

WOODSON, G. C., JR. 29 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

WOODWARD, J. G. 34 A FP
DAHLONEGA 30533

WOODWARD, STEPHEN C. 29 A
GEORGETOWN MED. SCH., WASHINGTON, DC 20007

WOODY, EDGAR, JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WORD, J. J. 2 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31061

WORTH, JACK J., JR. 29 ACT SL
490 PEACHTREE ST., N. E., ATLANTA 30308

WORTHY, W. STEVE 10 ACT OBG
115 HOSP. DR., CARROLLTON 30117

WRAY, BETTY B. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902

WRAY, CHARLES H. 54 ACT SL
TALMADGE MEM. HOSP., AUGUSTA 30902

WRIGHT, ASBURY D., JR. 34 ACT D
327 NORTHSIDE DR., N.W., GAINESVILLE 30501

WRIGHT, CHAS. K. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

WRIGHT, CLAUDE STARR 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

WRIGHT, DONALD A. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

WRIGHT, GEO. W. 54 DE5 SL
2913 BRANSFORD RD., AUGUSTA 30904

WRIGHT, J. CARTER 10 ACT SL
624 DIXIE ST., CARROLLTON 30117

WRIGHT, JAMES R. 34 ACT OPH
301 NORTHSIDE DR., N.W., GAINESVILLE 30501

WYATT, BARBARA 27 ACT I
3 PROFESSIONAL COURT, ROME 30161

WYATT, C. J., JR. 27 ACT I
5 PROFESSIONAL COURT, ROME 30161

WYATT, SPARKMAN H. 22 ACT P
2017 CESMOND DR., DECATUR 30033

WYLIE, JAMES E. 22 ACT OBG
365 WINN WAY, DECATUR 30030

WYLIE, M. H. 54 ACT SL
1403 GWINNETT ST., AUGUSTA 30904

WYNN, O. C. 72 DE5 FP
861 FOLKS ST., WAYCROSS 31501

WYNNE, MORGAN D., JR. 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093

WYNNE, ROBERT MILETUS 6 ACT FP
2305 INGLESIDE AVENUE, MACON 31204

WYSONG, EDWARD D. 78 ACT FP
123 GORDON ST., WASHINGTON 30673

Y

YAGER, HOWARD S. 29 ACT FP
3158 MAPLE DR., N.E., ATLANTA 30305

YAMPOLSKY, JOSEPH 29 DE5 PD
150 ROBIN HOOD RD., N. E., ATLANTA 30309

YANCEY, ASA G. 29 ACT SU
35 BUTLER ST., S.E., ATLANTA 30303

YARBROUGH, JAMES E. 47 A
1909 IRIS DRIVE, COLUMBUS 31906

YARBROUGH, J. F. 29 ACT ANES
384 PEACHTREE ST., N. E., ATLANTA 30308

YARBROUGH, SIDNEY H., III 47 ACT OR
1310 13TH AVE., COLUMBUS 31901

YARN, CHARLES P., JR. 29 ACT PL
35 COLLIER RD., N.W., ATLANTA 30309

YATES, A. J., JR. 57 ACT FP
SOPERTON 30457

YAUGER, JOHN THOMAS 29 ACT
353 PARKWAY DR., N.E., ATLANTA 30312

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P. O. BOX 2127, VALDOSTA 31603

YEARGIN, LOYD C. 76 ACT FP
P. O. BOX 429, DALTON 30720

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5112 PAULSEN ST., SAVANNAH 31405

YEOMANS, JAMES W. 75 ACT SL
P. O. BOX 67, JESUP 31545

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2687 OVERLOOK DR., N.E., ATLANTA 30345

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1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

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28 MEDICAL ARTS CENTER, SAVANNAH 31405

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213-B ARROWHEAD BLVD., JONESBORO 30236

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159 FORREST AVE., N. E., ATLANTA 30303

YUCEL, VEHBI E. 29 ACT PM
2040 RIDGEWOOD DR., N.E., ATLANTA 30307

YUN, IN W. 35 ACT FP
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Z

ZAKARIA, MAJED S. 16 ACT SL
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ZILIS, JAMES J. 21 ACT OBG
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ZIMMERMAN, W. F. 66 DE1 FP
TIFTON 31794

ZIRKLE, JOHN G. 11 ACT SL
14 MEDICAL ART CENTER, SAVANNAH 31405

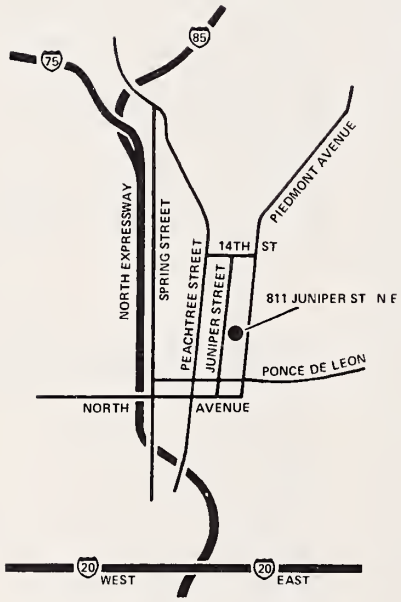
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ZWEIG, ARNOLD 22 ACT OTO
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ZWIREN, GERALD T. 29 ACT PD
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Accredited by the Joint Commission on Accreditation of Hospitals.

811 Juniper Street, N.E.
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Telephone
(404) 873-6151

METROPOLITAN PSYCHIATRIC CENTER centrally located in midtown Atlanta, provides comprehensive psychiatric care for adult and adolescent patients. Inpatient care, out-patient care and partial hospitalization programs are available at the Center. Alcohol patients are treated in a program directed toward recovery.

The following modalities of treatment, diagnostic procedures and ancillary services are available:

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- Group Psychotherapy
- Somatic Therapy
- Family Counseling
- Psychological Testing
- Social Work Services
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- Vocational Rehabilitation Counseling
- Consulting Staff—All Medical Specialties
- Full Laboratory Coverage—including EKG, EEG and Brain Scan
- Full Radiology Services
- Activity Therapy Programs including Occupational Therapy, Recreational Therapy, Art and Music Therapy









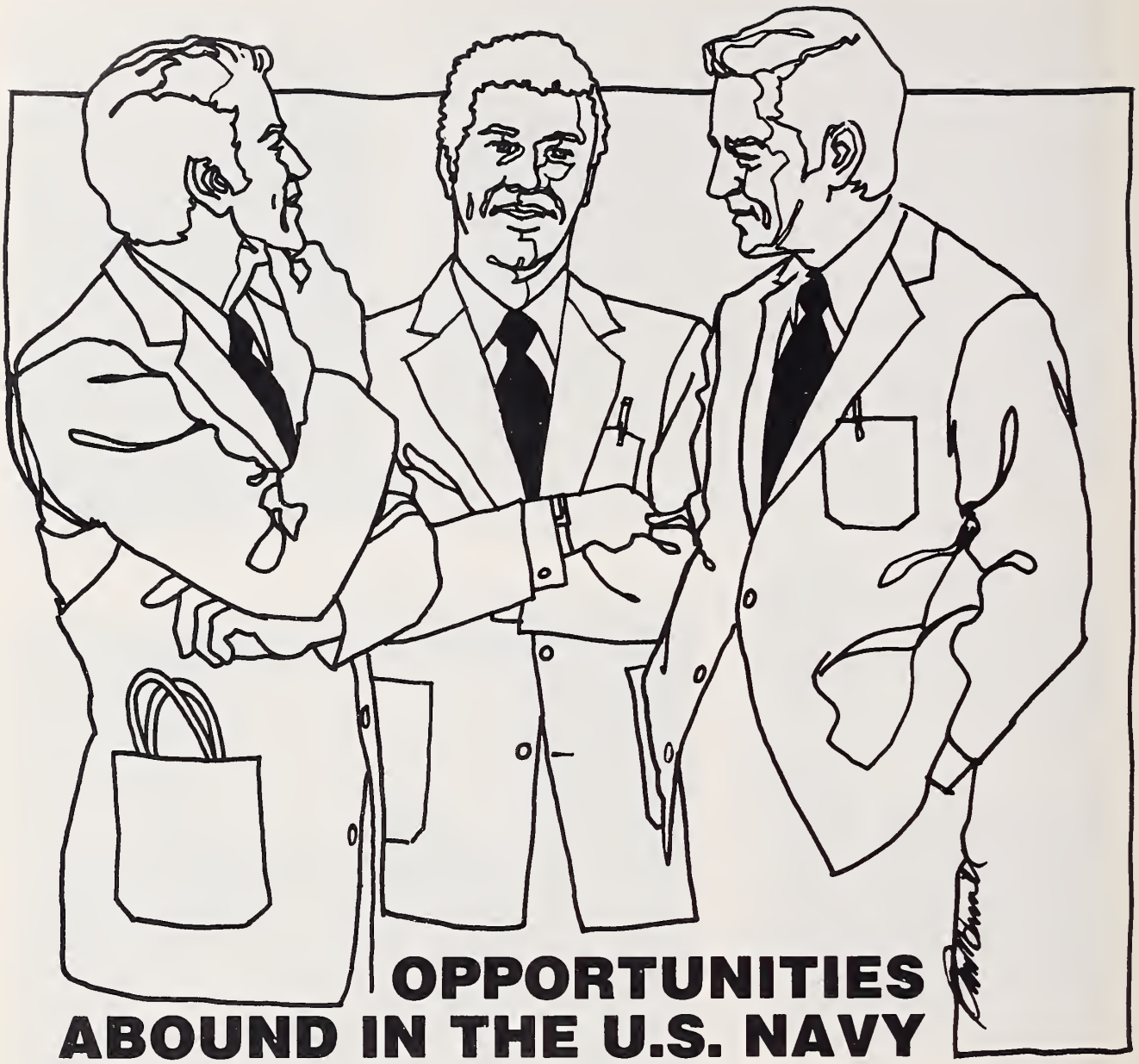
The attending psychiatrist determines from the comprehensive services available the most appropriate modality(s) of treatment but always within the theme of individualized care.

The Center provides 24 hour admission service.

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PASCUAL, RAFAEL R. 2 ACT P
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RANDOLPH, W. T. 3 DE5 FP
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SOUTHER, JOE C. 3 ACT FP
802 E. BROAD ST., WINDER 30680

4—BARTOW

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103 VALLEY DR., CARTERSVILLE 30120

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41 NELSON ST., CARTERSVILLE 30120

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15 WOODVIEW DR., CARTERSVILLE 30120

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19 NELSON ST., CARTERSVILLE 30120

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235 MEDICAL COURT, FORSYTH 31029

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1383 OGLETHORPE ST., MACON 31201

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P. O. BOX 352, GRAY 31032

GREENWALO, HERBERT S., JR 6 ACT ORH
380 HOSRITAL OR., MACON 31201

GRIFFIN, WARREN L., JR. 6 ACT OTO
800 FIRST ST., MACON 31201

GROSSMAN, CONRAD P. 6 ACT OBG
380 HOSP. DR., MACON 31201

HALL, JOHN I. 6 DE5 OR
P. O. BOX 6000, MACON 3120B

HALL, THOMAS M., II 6 ACT P
2437 VINEVILLE AVE., MACON 31204

HANBERRY, RICHARD L. 6 ACT OBG
657 HEMLOCK STREET, MACON 31201

HANSON, J. FLETCHER 6 DE5 I
3B34 THE RRADO, MACON 31204

HARPER, HENRY W., JR. 6 ACT ANES
742 CARTAIN KELL DR., MACON 31204

HATCHER, MILFORD B. 6 ACT SU
7B1 SRRING ST., MACON 31201

HAZELHURST, W. DERREL 6 ACT I
765 SRRING ST., MACON 31201

HERRING, JOHN S., JR. 6 ACT OBG
675 NEW ST., MACON 31201

HIGHTOWER, SAMUEL J. 6 ACT NS
740 HEMLOCK ST., MACON 31201

HODGES, MALCOLM R. 6 ACT FR
1221 NEWBURG AVE., MACON 31206

HOGAN, J. T., JR. 6 ACT FR
7B1 SPRING ST., MACON 31201

HOLOEN, WILLIAM H. 6 OE5 ALR
% H.S. COLBATH, 380 RVOL. RO., MACON 31204

HOLLOWAY, WILMER O. 6 ACT
R. O. BOX 38B, TIFTON 31794

HOMEYER, W. F., JR. 6 ACT ANES
1654 TWIN PINES OR., MACON 31201

HOOPER, ROBERT J. 6 ACT ORH
645 FIRST STREET, MACON 31201

HOUSER, FRANK M. 6 ACT FP
781 SPRING ST., MACON 31201

HUGHES, ANDREW J. 6 ACT FP
3741 HOUSTON AVE., MACON 31201

HURST, JAMES B. 6 ACT PATH
BALOWIN COUNTY HOSP., MILLEOGEVILLE 31061

IRELAND, CHARLES R. 6 ACT I
B11 ORANGE TERR., MACON 31201

JACKSON, GORDON W. 6 ACT OBG
380 HOSP. OR., MACON 31201

JAMES, C. W., JR. 6 ACT FP
3741 HOUSTON AVE., MACON 31206

JAMES, LILLAS L. 6 ACT FR
729 RINE ST., MACON 31201

JARRAT, W. O. 6 ACT ORH
626 FIRST ST., MACON 31201

JOHNS, CHARLES W. 6 ACT FR
3741 HOUSTON AVE., MACON 31206

JOHNSON, CLARENCE E., JR. 6 ACT SU
B70 HIGH STREET, MACON 31201

JOHNSON, MILTON I., JR. 6 ACT FR
2605 CHEROKEE AVE., MACON 31204

JOHNSTON, G. A. 6 ACT
755 MONROE STREET, MACON 31201

JONES, GEORGE R. 6 ACT ORH
626 FIRST ST., MACON 31201

JONES, HENRY B., JR. 6 ACT
GRAY 31032

JONES, JOHN R. 6 ACT PO
BB5 RINE ST., MACON 31201

JONES, ROBERT H. 6 ACT I
675 NEW ST., MACON 31201

JONES, RUDOLRH W., JR. 6 ACT I
BB3 PINE STREET, MACON 31201

JORDAN, WILLIAM K. 6 ACT OBG
675 NEW ST., MACON 31201

KAY, FERDINAND V. 6 ACT FR
1221 NEWBERG AVE., MACON 31206

KEEN, O. F. 6 OE5 SU
AMERICAN FEDERAL BLOG., MACON 31201

KELLY, ELMD C., III 6 ACT O
700 SRRING ST., MACON 31701

KELLY, GENE M. 6 ACT ANES
14B TEN KNOLLS OR., MACON 31204

KING, J. L. 6 OE5 I
283 BUFORD PL., MACON 31201

KING, J. LON, JR. 6 ACT OBG
380 HOSR. OR., MACON 31201

LANFORD, CHARLES A. 6 ACT FR
7405 IND. HWY., MACON 31206

LAWRENCE, JAMES D. 6 ACT SU
380 HOSR. DR., MACON 31201

LEWIS, WM. EARL 6 ACT SU
655-C FIRST ST., MACON 31201

LINDSAY, JAMES B. 6 ACT SU
7B1 SPRING ST., MACON 31201

LONGAKER, PAUL E. 6 ACT FR
4915-G RIVOLI OR., MACON 31204

MADDOX, S. F. 6 ACT OPH
800 FIRST ST., MACON 31201

MAGNAN, C. G., JR. 6 ACT PL
380 HOSR. DR., MACON 31201

MANN, DAVID S. 6 ACT
645 FIRST STREET, MACON 31201

MARTIN, J. O. 6 ACT ORH
745 PINE ST., MACON 31201

MASSENBURG, G. Y., JR. 6 ACT
700 SPRING ST., MACON 31201

MAURIZI, CHARLES R. 6 ACT RATH
777 HEMLOCK ST., MACON 31201

MAYES, ALVA LOUIE, JR. 6 ACT RO
2009 VINEVILLE AVE., MACON 31204

MAYS, J. R. S. 6 DE5 R
700 SPRING ST., MACON 31201

MCALLISTER, ROBERT W. 6 ACT P
N. HOUSTON RO., A-1, WARNER ROBINS 31093

MCCARO, RAY H. 6 ACT P
596 ARLINGTON PL., MACON 31201

MCLENDON, JOE L. 6 ACT OPH
P. O. BOX 956, MACON 31202

MCMICHAEL, ROBERT S. 6 ACT FP
2869 NAPIER AVENUE, MACON 31204

MCMILLAN, E. C., JR. 6 ACT SU
670 NEW ST., MACON 31201

MENENDEZ, JACK F. 6 ACT SU
700 SRRING ST., MACON 31201

METTS, BETTY HOGAN 6 ACT ANES
723 CAPTAIN KELL DR., MACON 31204

MOODY, RAYMOND A. 6 ACT FP
755 ORANGE ST., MACON 31201

NEAL, JULE C., JR. 6 ACT OBG
380 HOSP. DR., MACON 31201

NELSON, HOMER S. 6 ACT OPH
BOX 956, MACON 31202

NEUBERG, S. CHARLOTTE 6 ACT
608 AMERICAN FEDERAL BLDG., MACON 31201

NEWMAN, W. A. 6 OE5 OR
4-O MASSEE APTS., MACON 31201

NEWTON, MILLEGE C. 6 ACT I
380 HOSPITAL DR., MACON 31201

NEWTON, RALPH G., JR. 6 ACT U
718 FIRST ST., MACON 31201

NEWTON, W. R. 6 ACT
801 SRRING ST., MACON 31201

OLNICK, HERBERT M. 6 RET R
724 HEMLOCK ST., MACON 31201

ORR, WILLIAM W. 6 ACT PD
2009 VINEVILLE AVE., MACON 31204

OSHAUGHNESSEY, W. JHN JR. 6 ACT I
724 HEMLOCK ST., MACON 31201

PAGE, JOHN A. 6 ACT OPH
800 FIRST ST., MACON 31201

PATTON, PAUL B. 6 ACT I
777 HEMLOCK ST., MACON 31204

PATTON, SAMUEL E. 6 ACT I
P. O. BOX 4605, MACON 31208

PENNINGTON, CLAUDE LEE 6 ACT ALR
800 FIRST STREET, MACON 31201

PHELPS, PAUL R. 6 ACT SU
781 SPRINGS ST., MACON 31201

PHILLIPS, A. M., JR. 6 ACT OR
380 HOSPITAL DR., MACON 31201

PHILLIPS, JAMES E. 6 ACT PATH
4946 BRITTANY DR., MACON 31204

PIRKLE, T. N. 6 ACT R
P.O. BOX 1002, CORDELE 31015

PHELPS, PAUL R. 6 ACT SU
781 SPRING ST., MACON 31201

POUND, WILLIAM E. 6 ACT FP
670 NEW STREET, MACON 31201

POWELL, MATTHEW J. G. 6 ACT FP
MEDICAL CENTER OF CENTRAL GA., MACON 31204

PRIM, CARY J. 6 ACT ANES
1860 FLINTWOOD DR., MACON 31201

RANOO, STEPHEN 6 ACT R
752 HEMLOCK ST., MACON 31201

RAWLS, LEWIS L. 6 OE5 FP
1107 SOUTHERN TRUST BLDG., MACON 31201

RAYBOURNE, JACK E. 6 ACT ANES
2934 VICTORIA CIR., MACON 31201

REIFLER, R. M. 6 ACT D
729 PINE ST., MACON 31201

RHAME, OONALO W. 6 ACT SU
700 SPRING ST., MACON 31201

RICHARDSON, CHAS. H. 6 DE5 SU
2749 CHEROKEE AVE., MACON 31204

RICHARDSON, C. H., JR. 6 ACT SU
724 HEMLOCK ST., MACON 31201

RIDLEY, C. L., JR. 6 ACT SU
380 HOSRITAL OR., MACON 31201

ROBINSON, JOE S. 6 ACT SU
655 FIRST ST., MACON 31201

ROODENBERRY, HARVEY B. 6 ACT OBG
380 HOSPITAL DR. SUITE 100, MACON 31201

ROGERS, JAMES W. 6 ACT EM
3055 GENERAL LEE RO., MACON 31204

ROGERS, T. E., JR. 6 ACT OBG
856 FIRST ST., MACON 31201

ROSS, THOMAS L. 6 ACT I
944 NOTTINGHAM DR., MACON 31201

ROWLEY, CHARLES M. 6 ACT N
755 ORANGE TERR., MACON 31201

ROZIER, O. H. 6 ACT ANES
5151 ZEBULON RD., MACON 31204

RUMBLE, CHAS. T. 6 ACT PO
RT. 3, BOX 43, FORSYTH 31029

SANDERS, BEVERLY B., JR. 6 ACT D
700 SPRING ST., MACON 31201

SCHLOTTMAN, GEORGE C. 6 ACT U
718 FIRST ST., MACON 31201

SCHOFFSTALL, ROBERT O.. 6 ACT SU
P. O. BOX 6000, MACON 31208

SCHUESSLER, CARL C. 6 ACT OBG
380 HOSRITAL OR., MACON 31201

SCHWARTZ, LARRY A. 6 ACT PD
376 ROGERS AVE., MACON 31204

SCHWARTZ, ROBERT I. 6 ACT PD
376 ROGERS AVE., MACON 31204

SEALY, HUGH K. 6 ACT I
765 SPRING ST., MACON 31201

SEWELL, JESSE Q. 6 ACT FP
784 SPRING ST., MACON 31201

SHELOR, WILLIAM C., JR. 6 ACT U
718 FIRST ST., MACON 31201

SHIELOS, JOSEPH D., III 6 ACT I
724 HEMLOCK ST., MACON 31201

SHIRLEY, WM. C. 6 ACT OBG
380 HOSP. OR., MACON 31201

SIKES, ZACHARIAH S., JR. 6 ACT P
803 SPRING ST., MACON 31201

SMISSON, HUGH F. 6 ACT NS
740 HEMLOCK ST., MACON 31201

SMITH, JAMES E. 6 A SU
777 HEMLOCK ST., MACON 31201

SMITH, J. GREGG 6 OE5 PH
160 INOIAN SPRINGS RD., FORSYTH 31029

SMITH, NAT E. 6 ACT I
MERCER UNIVERSITY, MACON 31201

SMITH, PATTON P. 6 ACT FP
235 MEDICAL COURT, FORSYTH 31029

SOMERS, WM. H. 6 ACT R
P. O. BOX 6000 MACON 31208

SOUMA, JOHN A. 6 S OBG
MARTIN ARMY HOSP., FT. BENNING 31906

SPIVEY, OSCAR S. 6 ACT PO
2009 VINEVILLE AVE., MACON 31204

SREERAM, K. M. 6 ACT TS
700 SPRING ST., MACON 31201

STEVENS, EDWARD L. 6 ACT OALR
800 FIRST STREET, MACON 31201

STEWART, J. BENHAM 6 ACT SU
700 SPRING ST., MACON 31201

SUAREZ, RAYMONO 6 OE5 FP
844 PARKVIEW OR., MACON 31201

SWILLING, EVELYN 6 ACT OB
844 PARKVIEW OR., MACON 31201

TARRANT, GRACE L. 6 ACT R
MEDICAL CENTER, MACON 31201

TIOWELL, REX W. 6 ACT R
380 HOSP. OR., MACON 31201

TIFT, HENRY H. 6 ACT I
765 SPRING ST., MACON 31201

WALKER, DUNCAN, JR. 6 ACT ALR
700 SRRING ST., MACON 31201

WALKER, ROBERT J., JR. 6 ACT PH
770 HEMLOCK ST., MACON 31201

WATSON, EDWIN R. 6 ACT PD
745 PINE ST., MACON 31201

WEAVER, ALEXANDER H. S. 6 ACT OR
P. O. BOX 6317, MACON 31208

WEAVER, WILLIAM H. M. 6 ACT I
700 SPRING STREET, MACON 31201

WELLS, JAMES M. 6 OE1 ANES
2983 VICTORIA OR., MACON 31201

WELLS, JOHN A. 6 ACT SU
724 HEMLOCK ST., MACON 31201

WHITE, HENRY C., JR. 6 ACT I
2009 VINEVILLE AVE., MACON 31204

WILLIAMS, DAVID C., SR. 6 OE5 P
1142 CRUID PARK AVE., AUGUSTA 30904

WILLIAMS, OONALO D. 6 ACT EM
1261 TWIN PINES DR., MACON 31201

WILLIAMS, H. J., JR. 6 ACT PO
1624 COLEMAN AVENUE, MACON 31201

WILLIAMS, THOMAS H. 6 ACT SU
781 SPRING ST., MACON 31201

WILLIAMS, WM. A., JR. 6 ACT FP
5297 BRANDYWINE OR., MACON 31204

WOOOHALL, J. P. 6 ACT SU
724 HEMLOCK ST., MACON 31201

WYNNE, ROBERT MILETUS 6 ACT FP
2305 INGLESIDE AVENUE, MACON 31204

7—BLUE RIDGE
(Fannin, Gilmer, Union)

BURNS, R. A. 7 ACT FP
BLUE RIDGE 30513

FERNANDEZ, E. J. 7 ACT FP
SPRING ST., ELLIJAY 30540

HAYMORE, JAMES M. 7 ACT FP
BOX 578, BLUE RIDGE 30513

PLINKE, ROBERT W. 7 ACT FP
HWY 5, SOUTH, ELLIJAY 30540

8—OGEECHEE RIVER
(Bulloch, Candler, Evans, Jenkins)

ANDERS, MACELYN V. 8 ACT FP
MED. DIR. GA. SOU. COLL., STATESBORO 30458

BOHLER, CHARLES EMORY 8 ACT FP
BOX 8, BROOKLET 30415

CLEMONS, THURMAN 8 ACT FP
P. O. BOX 821, STATESBORO 30458

CURRY, LEON E. 8 ACT FP
P. O. BOX 267, METTER 30439

OANIEL, A. B. 8 ACT SU
P. O. BOX 717, STATESBORO 30458

DEAL, ALBERT M. 8 ACT SU
P. O. BOX 647, STATESBORO 30458

OEAL, HELEN R. 8 ACT PO
P. O. BOX 647, STATESBORO 30458

DEAL, JOHN D. 8 ACT FP
P. O. BOX 1043, STATESBORO 30458

HAMES, CURTIS G. 8 ACT I
CLAXTON 30417

HENDLEY, JOHN ELL 8 ACT FP
101 E. COLLEGE AVE., MILLEN 30442

KENT, WILLIAM F. 8 ACT OBG
P. O. BOX 1066, STATESBORO 30458

LOVETT, KATHRYN S. 8 ACT P
R. O. BOX 486, STATESBORO 30458

MOONEY, A. JOHN 8 ACT
P. O. BOX 527, STATESBORO 30458

MULKEY, A. R. 8 ACT SU
110 E. COLLEGE AVE., MILLEN 30442

PENCE, ROBERT L. 8 ACT
P. O. BOX 388, METTER 30439

RICHARDSON, CHARLES R. 8 ACT OBG
P. O. BOX 1066, STATESBORO 30458

ROBINSON, ROBERT S. 8 ACT FP
R. O. BOX 45, METTER 30439

SMITH, HERBERT D. 8 ACT P
127 N. MAIN ST., STATESBORO 30458

SMITH, J. DORSEY 8 ACT FP
MEDICAL ASSOC. OF METTER., METTER 30439

STAMBUK, ROBERT B. 8 ACT R
P. O. BOX 1048, STATESBORO 30458

SWINT, ROBERT H. 8 ACT SU
P. O. BOX 1088, STATESBORO 30458

THOMPSON, JOSIAH 8 ACT SU
MCKINLEY & SMITH STS., CLAXTON 30417

TILLMAN, SAMUEL P. 8 ACT I
302 DONEHOO ST., STATESBORO 30458

9—BURKE

BYNE, J. M., JR. 9 ACT I
LIBERTY ST., WAYNESBORO 30830

GREEN, CHARLES G. 9 ACT FP
223 EAST 6TH ST., WAYNESBORO 30830

HENSLEY, E. R. 9 ACT
CORNER CHURCH & COUNCIL, WAYNESBORO 30830

MURRAY, B. LAMAR 9 ACT
FOURTH ST., WAYNESBORO 30830

THOMPSON, CLEVELAND, JR. 9 DE1 FP
RT 2 BOX P-47 F, SANTEE, SC 29142

VOYLES, WALTER R. 9 ACT SU
307 FOURTH ST., WAYNESBORO 30830

10—CARROLL-DOUGLAS-HARALSON

ALLEN, R. D. 10 ACT
TALLAPOOSA 30176

ARRENDALE, JOE J. 10 ACT FP
8435 PRICE AVE., DOUGLASVILLE 30134

ASTIN, PHIL C., JR. 10 ACT FP
702 DIXIE STREET, CARROLLTON 30117

BATCHELOR, CURTIS A. 10 ACT FP
405 ALABAMA ST., BREMEN 30110

BERRY, ROBERT L. 10 ACT FP
VILLA RICA 30180

BOSS, JAMES L. 10 ACT FP
VILLA RICA 30180

COLDITZ, RICHARD B. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117

CENNEY, ROY L. 10 ACT OALR
CARROLLTON 30117

DOWNEY, W. P. 10 ACT FP
TALLAPOOSA 30176

ELDER, IVAN R. 10 ACT FP
MEDICAL CLINIC, BREMEN 30110

GRANT, EDWIN H. 10 ACT R
TANNER MEMORIAL HOSP., CARROLLTON 30117

GREEN, JAMES FRANKLIN 10 ACT FP
POWELL CLINIC, VILLA RICA 30180

GRESHAM, WALTER S. 10 ACT
BOWDEN 30108

JOHNSON, MARTIN L. 10 ACT
BOWDON 30108

KIM, IN SOOK 10 ACT I
201 ALLEN MEMORIAL DR., BREMEN 30110

KIM, PYUNG JUNG 10 ACT SU
201 ALLEN MEMORIAL DR., BREMEN 30110

MARTIN, TALMAGGE M. 10 ACT SU
619 DIXIE STREET, CARROLLTON 30117

MCLENDON, HAROLD L. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117

MCLENDON, JULIAN K. 10 ACT
405 ALABAMA AVENUE, BREMEN 30110

MERRITT, CHARLES R. 10 ACT PD
107 CLINIC AVE., CARROLLTON 30117

PARRISH, JOE E. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117

PATRICK, E. V. 10 ACT I
CARROLLTON 30117

POWELL, JOHN E., JR. 10 ACT FP
VILLA RICA 30180

PRITCHETT, JOHN F., JR. 10 ACT
BREMEN 30110

REEVE, THOMAS E., JR. 10 ACT SU
CARROLLTON 30117

REID, RAYMOND J., JR. 10 ACT FP
P. O. BOX 325, TALLAPOOSA 30176

ROBINSON, A. CLARK 10 ACT FP
P. O. BOX 1116, DOUGLASVILLE 30134

ROBINSON, J. C. 10 ACT R
TANNER MEM. HOSP., CARROLLTON 30117

SMITH, WILLIAM P., JR. 10 ACT SU
BOWDON 30108

STRICKLER, D. T., JR. 10 ACT FP
P. O. BOX 518, DOUGLASVILLE 30134

TAYLOR, THOMAS B. 10 ACT
DOUGLASVILLE 30134

VANSANT, CLAUDE V., SR. 10 DE5 FP
DOUGLASVILLE 30134

WORTHY, W. STEVE 10 ACT OBG
115 HOSP. DR., CARROLLTON 30117

WRIGHT, J. CARTER 10 ACT SU
624 DIXIE ST., CARROLLTON 30117

11—GEORGIA MEDICAL SOCIETY (Bryan, Chatham, Effingham, Liberty, Long, McIntosh)

ALEXANDER, J. L. 11 ACT SU
40 MEDICAL ARTS CENTER, SAVANNAH 31405

ALVAREZ, M. L. 11 ACT PATH
1804 STILLWOOD DR., SAVANNAH 31406

ANGELL, JOHN F. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403

APPLETON, BROWN G. 11 ACT EM
P.O. BOX 6688, ST. C, SAVANNAH 31405

ARKIN, MURRAY C. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405

BALL, WESLEY J. 11 ACT SU
1814 ABERCORN ST., SAVANNAH 31401

BARGERON, EUGENE P. 11 ACT OR
P.O. BOX 6156, SAVANNAH 31405

BEDINGFIELD, W. O., 11 DE5
1020 DRAYTON ST., SAVANNAH 31401

BEESON, CHARLES W., II 11 ACT C
803 E. 70TH ST., SUITE 103, SAVANNAH 31405

BERENS, SANFORD V. 11 ACT R
5223 PAULSEN ST., SAVANNAH 31405

BERLIN, MELVIN 11 ACT
1 MIDTOWN MEDICAL CENTER, SAVANNAH 31401

BODZINER, L. S. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405

BOUSQUET, FRANKLYN P., JR 11 ACT OPH
P.O. BOX 13919, SAVANNAH 31402

BOWDEN, RALPH O. 11 ACT
22 W. TAYLOR ST., SAVANNAH 31401

BRADBURY, ROBERT G. 11 ACT R
311 E. HALL ST., SAVANNAH 31401

BRANDT, HENRY A. 11 ACT PN
220 EAST HALL STREET, SAVANNAH 31401

BRAWNER, D. L. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403

BRENNAN, CARL H. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405

BRODERICK, JOHN R. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

BROWN, ALAN P. 11 ACT EH
P. O. BOX 13312, SAVANNAH 31406

BROWN, CHARLES T. 11 DE5 PH
BOX 7, GUYTON 31312

BROWN, F. BERT 11 DE1 OR
17 E. 52ND ST., SAVANNAH 31405

BUCKHAULTS, W. W. 11 ACT OPH
905 ABERCORN STREET, SAVANNAH 31401

BUELVAS, RAUL S. 11 ACT SU
11706 MERCY BLVD., SAVANNAH 31406

BURGSTINER, CARSON B. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401

CANNON, CLIFTON L., JR. 11 ACT NS
22 MEDICAL ARTS CTR., SAVANNAH 31405

CAPLAN, GERALD E. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405

CARLTON, FRANK E. 11 ACT U
P.O. BOX 3458, SAVANNAH 31403

CARTER, ROBERT H. 11 ACT SU
1020 DRAYTON ST., SAVANNAH 31401

CENTER, A. H. 11 ACT PN
10 MEDICAL ARTS CENTER, SAVANNAH 31405

CIRINCIONE, V. J. 11 ACT O
46 MEDICAL ARTS CENTER, SAVANNAH 31405

CLARKE, GEORGE O. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

CLARY, W. UPTON 11 ACT NS
22 MEDICAL ARTS CENTER, SAVANNAH 31405

CLAYTON, MAX L. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405

COBB, ELLIOTT A. 11 ACT
P. O. BOX 6688, STAT C, SAVANNAH 31405

COLMERS, RUDOLF A. 11 ACT I
217 E HUNTINGDON ST., SAVANNAH 31401

COSTA, CONRADO V., JR. 11 ACT FP
P. O. BOX 9787, SAVANNAH 31402

CRYMES, JOHN M. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAV 31405

DAILY, F. WILLSON 11 ACT ANES
36 MECICAL ARTS CENTER, SAVANNAH 31405

DANZIG, LAMONT EARL 11 ACT I
P. O. BOX 5086, SAVANNAH 31403

DEKLE, JOHN L., JR. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403

DELANCY, HERMAN 11 ACT SU
5102 PAULSEN ST., SAVANNAH 31405

DEL RIO, GABRIEL G. 11 ACT PD
P. O. BOX 6688, SAVANNAH 31405

DE REAMER, JOHN W. 11 DE1 D
121 E. JONES ST., SAVANNAH 31401

DERISO, H. CLARK 11 ACT OR
44 MECICAL ARTS CENTER, SAVANNAH 31405

DI BENEDETTO, ROBERT J. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405

DIMONG, KEITH A. 11 ACT NE
P. O. BOX 5086, SAVANNAH 31405

DOOLAN, JOHN J., JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401

DOWNING, EDWARD F. 11 ACT NS
22 MECICAL ARTS CTR., SAVANNAH 31405

DUNCAN, J. HARRY 11 ACT OPH
P.O. BOX 3008, SAVANNAH 31403

DUNN, LAURENCE B. 11 DE5 FP
P. O. BOX 205, BLUFFTON, S. C. 29910

DYNIN, MICHAELA 11 ACT P
P. O. BOX 13607, SAVANNAH 31406

EDWARDS, A. JOSEPH, JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401

EDWARDS, ERNEST G., JR. 11 ACT OR
44 MEDICAL ARTS CENTER, SAVANNAH 31405

ELLIOTT, J. L. 11 DE5 I
212 E. HUNTINGDON ST., SAVANNAH 31401

ERMUTLU, ILHAN M. 11 ACT P
P. O. BOX 119, COLUMBIA, SC 29202

EVANS, JAMES P. 11 ACT PD
5102 PAULSEN ST., NO. 3, SAVANNAH 31405

FAGIN, RONALD R. 11 ACT I
5102 PAULSEN ST., SAVANNAH 31405

FILLINGIM, DAVID B. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401

FILLINGIM, DAVID W. 11 ACT OBG
1 ST. JOSEPH PROF. PLAZA, SAVANNAH 31406

FILLINGIM, JOHN M. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401

FILSON, EDGAR J. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405

FINGER, ELLIOTT R. 11 ACT PL
38 MEDICAL ARTS CENTER, SAVANNAH 31405

FREEDMAN, L. M. 11 ACT SU
FREDERICK PL 105, 803 E 70TH, SAVANN 31405

FREEMAN, THOMAS R. 11 ACT SU
200 EAST 31ST STREET, SAVANNAH 31401

FULMER, WM. HENRY 11 ACT FP
22 E. 34TH ST., SAVANNAH 31401

GERMAN, THOMAS L. 11 ACT OR
210 HALL ST. EAST, SAVANNAH 31401

GLENN, FRANK D. 11 I&R U
P.O. BOX 6688, SAVANNAH 31405

GOLDENSTAR, G. W. 11 ACT OPH
26 MEDICAL ARTS CENTER, SAVANNAH 31405

GONGAWARE, ROBERT D. 11 ACT SU
200 E. 31ST ST., SAVANNAH 31401

GONGAWARE, THEDDORA L. 11 ACT I
P.O. BOX 6688, STAT C, SAVANNAH 31405

GOODWIN, BURTON O., JR. 11 ACT R
P. O. BOX 6688, SAVANNAH 31401

GOTTSCHALK, ROBERT BRUCE 11 ACT SU
1 MEDICAL ARTS CENTER, SAVANNAH 31405

GUERRY, RODERICK L. 11 ACT PATH
P. O. BOX 9787, CANDLER HOSP., SAV 31402

HABERMAN, GEORGE G. 11 ACT SU
P. O. BOX 9787, SAVANNAH 31402

HADAWAY, PHIL L. 11 ACT FP
716 E. 71ST ST., SAVANNAH 31405

HADDAD, LESTER M. 11 ACT EM
P. O. BOX 6688, STE. C, SAVANNAH 31405

HAHN, EDWARD E. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406

HAM, OSCAR EMERSON 11 ACT PD
835 E. 65TH ST., SAVANNAH 31405

HARRIS, JOHN A. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

HARTMANN, HARRY R. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405

HEFFERNAN, J. ANTHONY, JR 11 ACT FP
20 MEDICAL ARTS CENTER, SAVANNAH 31405

HETHERINGTON, THOMAS A. 11 ACT R
311 E. HALL ST., SAVANNAH 31401

HOFFMAN, FRANK 11 ACT ALR
24 MEDICAL ARTS CENTER, SAVANNAH 31405

HOLLOMAN, J. J. 11 ACT FP
313 E. HALL STREET, SAVANNAH 31401

HOOD, E. D. 11 ACT FP
241 ABERCORN ST., SAVANNAH 31401

HOWARD, JOHN C. 11 ACT DALR
317 E. HALL STREET, SAVANNAH 31401

HOWARD, LEE, JR. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403

HOWARD, ROBERT M. 11 ACT PATH
P.O. BOX 133, SAVANNAH 31406

HUFFMAN, GALEN C. 11 ACT P
P.O. BOX 3608, RADFORD, VA. 24141

JACKSON, JAMES W. 11 ACT SL
1 MED. ARTS CENTER, SAVANNAH 31405

JENNINGS, JANE B. 11 ACT PATH
P. O. BOX 6688, SAVANNAH 31404

JOHNSON, G. HUGO, JR. 11 OE5
116 E. OGLETHORPE AVE., SAVANNAH 31401

JOHNSTON, FRANK M. 11 ACT PN
P. O. BOX 13146, SAVANNAH 31404

JORDAN, CARL R. 11 ACT SL
P. O. BOX 3567, STA. B, SAVANNAH 31404

JUDY, JAMES C. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405

JURGENSEN, PAUL F. 11 ACT I
P. O. BOX 5086, SAVANNAH 31403

KANTER, W. W. 11 ACT
P. O. BOX 9621, SAVANNAH 31402

KELLY, JULIAN D., JR. 11 ACT OR
11 W. GORDON ST., SAVANNAH 31401

KELLY, WILLIAM D. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406

KESSLER, FRED DTTO, JR. 11 ACT FP
3802 WATERS AVE., SAVANNAH 31404

KING, RUSKIN 11 OE5 PD
10 W. TAYLOR ST., SAVANNAH 31401

KUGLER, MORRIS A. 11 ACT SU
1 MEDICAL ARTS CENTER, SAVANNAH 31405

KUGLER, MORRIS A. 11 ACT SU
1 MEDICAL ARTS CENTER, SAVANNAH 31405

KURZBACH, ELMER 11 ACT FP
314 E. GASTON ST., SAVANNAH 31401

LANGE, STEPHEN J. 11 ACT FP
509 LEE BLVD., SAVANNAH 31405

LANGE, STEPHEN J., JR. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

LANIER, LONNIE R., JR. 11 ACT DBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405

LEE, JAMES MOULTRIE 11 ACT SU
200 E. 31ST. ST., SAVANNAH 31401

LEE, LAWRENCE, JR. 11 ACT I
2203 ABERCORN STREET, SAVANNAH 31401

LIPPITT, WILLIAM H. 11 ACT SU
200 EAST 31ST STREET, SAVANNAH 31401

LOGAN, JAMES R. 11 ACT OTO
2203 ABERCORN ST., SAVANNAH 31401

LONG, ROBERT F. 11 ACT R
P. O. BOX 6688, ST. C, SAVANNAH 31405

LONG, W. V. 11 DE5 SU
103 E. JONES ST., SAVANNAH 31401

LOTT, OSCAR H. 11 DE1 FP
RFD RT. 2, DOUGLAS 31533

LYNCH, LAWRENCE J., JR. 11 ACT SU
5102 PAULSEN ST., BLDG. F, SAVANNAH 31405

MANER, FREDERICK DEBELE 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

MARTENSON, EDGAR 11 ACT FP
42 MEDICAL ARTS, SAVANNAH 31405

MAZO, MILTON 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405

MCDEW, STEPHEN M. 11 ACT DBG
918 W. BROAD ST., SAVANNAH 31401

MCGEE, HARRY H., JR. 11 ACT R
311 E. HALL ST., SAVANNAH 31401

MCGOLDRICK, THOMAS A., JR 11 ACT I
15 E. GORDON ST., SAVANNAH 31401

MCREYNOLDS, B. A. 11 ACT SU
224 E. 46TH ST., SAVANNAH 31405

METTS, JAMES C. 11 OE5 I
110 W. GASTON ST., SAVANNAH 31401

METTS, JAMES C., JR. 11 ACT I
110 W. GASTON ST., SAVANNAH 31401

MILLER, WILLIAM A. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405

MOORE, RICHARD W. 11 ACT FP
905 MONTGOMERY ST., SAVANNAH 31401

MOORMAN, CLAUDE T., II 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

MORELAND, ROBERT H., JR. 11 ACT FP
709 BONNYRIDGE ROAD, PT. WENTWORTH 31407

MORGAN, HARVEY V. 11 ACT FP
1805 ABERCORN ST., SAVANNAH 31401

MORRISON, CHARLES W. 11 ACT PL
11 MEDICAL ARTS CTR., SAVANNAH 31405

MORRISON, JOSEPH V., JR. 11 ACT PD
4 MEDICAL ARTS CTR., SAVANNAH 31405

MULHERIN, JOSEPH A. 11 ACT ANES
711 E. 44TH ST., SAVANNAH 31405

MURPHY, HARVEY J. 11 ACT SL
5112 PAULSEN ST., SAVANNAH 31405

NASH, O. A. 11 ACT FP
5720 COLONIAL DR., SAVANNAH 31406

NETTLES, JOE L. 11 ACT OR
P. O. BOX 6156, SAVANNAH 31405

NEVILLE, RUFUS L., JR. 11 ACT U
2115 BULL ST., SAVANNAH 31401

NICHOLS, FENWICK T., JR. 11 ACT I
P. O. BOX 6167, SAVANNAH 31405

NORTHUP, JOHN O. 11 ACT GE
5705 PAULSEN ST., STE 125, SAVANNAH 31405

OLIVER, ROBERT LEE 11 DE5 SU
DE RENNE APTS., SAVANNAH 31401

OLSON, CLYDE L. 11 ACT DPH
P. O. BOX 8905, SAVANNAH 31402

ORTIZ, JESUS 11 ACT P
5105 PAULSEN ST., SAVANNAH 31405

OSBORNE, E. S. 11 DE5 DALR
P.O. BOX 870, SAVANNAH BEACH 31328

OSBORNE, W. W. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401

OSTEEN, CLARK L. 11 ACT ANES
206 W. BAY ST., SAVANNAH 31401

PACIFICI, JOSEPH 11 ACT FP
2 E. TAYLOR ST., SAVANNAH 31401

PASTORIUS, GEORGE J. 11 DE1 ANES
3601 BULL ST., SAVANNAH 31405

PETERSON, T. A. 11 ACT FP
11 W. JONES ST., SAVANNAH 31401

PHILLIPS, ANDRO P. 11 ACT FP
323 EAST JONES STREET, SAVANNAH 31401

PIATT, EDWARD D. 11 ACT R
9 MEDICAL ARTS CTR., SAVANNAH 31405

PIKE, BENJAMIN L. 11 ACT I
32 MEDICAL ARTS CENTER, SAVANNAH 31405

PORTER, JOHN E. 11 ACT FP
5105 PAULSEN ST., SAVANNAH 31405

PORTMAN, H. J. 11 ACT PD
118 E. 34TH ST., SAVANNAH 31401

POWERS, LEANDER K. 11 ACT FP
29 E. JONES ST., SAVANNAH 31401

PRITZKER, MARTIN S. 11 ACT D
P. O. BOX 13603, SAVANNAH 31406

QUATTLEBAUM, J. K. 11 DE5 SU
3701 WATERS AVE., SAVANNAH 31401

QUATTLEBAUM, J. K., JR. 11 ACT SU
P.O. BOX 9787, SAVANNAH 31402

QUATTLEBAUM, ROBERT, JR. 11 ACT U
P. O. BOX 3458, SAVANNAH 31403

RABUN, J. B. 11 ACT R
311 E. HALL STREET, SAVANNAH 31401

RAMSEY, SPEIR N. 11 ACT OBG
19 MED. ARTS CENTER, SAV. 31405

RAWSON, CLARENCE W., JR. 11 ACT DR
P. O. BOX 6156, SAVANNAH 31405

REEVES, J. LANE 11 ACT OPH
P. O. BOX 8909, SAVANNAH 31402

RHANGOS, WILLIAM C. 11 ACT DR
210 E. HALL ST., SAVANNAH 31401

ROBERTSON, MASON G. 11 ACT I
P. O. BOX 13160, SAVANNAH 31406

ROBINSON, DAVID 11 A R
4745 FAIRFAX DR., SAVANNAH 31405

ROLLINGS, HARRY E. 11 ACT I
100 E. PARK AVE., SAVANNAH 31401

ROQUE, R. T. 11 ACT FP
SPRINGFIELD MED. PROF., SPRINGFIELD 31329

ROSE, DANIEL W. 11 ACT OTO
17 MEDICAL ARTS CENTER, SAVANNAH 31405

ROSEN, E. F. 11 ACT DALR
5 E. GORDON STREET, SAVANNAH 31401

ROSEN, SAMUEL F. 11 OE5 D
P.O. BOX 960, SAVANNAH BCH. 31328

ROSENGART, CARL L. 11 ACT N
P.O. BOX 6683, SAVANNAH 31405

ROSSITER, FRANCIS P., JR. 11 ACT AL
5 MIDTOWN MEDICAL CENTER, SAVANNAH 31401

RUSSELL, ALEX P. 11 ACT PATH
MEMORIAL MEDICAL HOSP., SAV. 31405

SAFER, IRWIN H. 11 ACT P
515 E. 63 ST., SAVANNAH 31405

SALTER, W. L. 11 DE1 FP
B915-A OLD MONTGOMERY RD., SAV. 31406

SAX, CHARLES E. 11 ACT OBG
120 E. 34TH STREET, SAVANNAH 31401

SCARBROUGH, ROGER W., JR. 11 ACT OBG
11706 MERCY BLVD., SAVANNAH 31406

SCARDINO, PETER L. 11 ACT U
P. O. BOX 3458, SAVANNAH 31403

SCHLEY, RICHARD L., JR. 11 ACT PO
5509 PAULSEN ST., SAVANNAH 31405

SCHULZE, RICHARD R. 11 ACT OPH
728 E. 67TH ST., SAVANNAH 31405

SELTZER, STEPHEN C. 11 ACT I&R
1200 N. ELM ST., GREENSBORO, NC 27401

SERRANO, GABRIEL 11 ACT FP
6 MEDICAL ARTS, SAVANNAH 31405

SHARPLEY, H. F., JR. 11 DES PO
P. O. BOX 5054, SAVANNAH 31403

SHARPLEY, JOHN G. 11 ACT SU
1903 ABERCORN ST., SAVANNAH 31401

SHEILS, ANDREW T., JR. 11 ACT OR
#7 ST. JOSEPHS PROF. PLAZA, SAVANNAH 31406

SHEPHERD, EDWIN C. 11 ACT PO
4 MEDICAL ARTS CENTER, SAVANNAH 31405

SHEPPECK, MICHAEL L. 11 ACT AOM
P.O. BOX 13607, SAVANNAH 31406

SHERMAN, ELOISE B. 11 ACT PATH
P. O. BOX 6542, STAT. C, SAVANNAH 31405

SHUMAN, IVY L., JR. 11 I&R
4604-G CORONADO DR., CHARLOTTE, NC 28212

SIMS, JAMES A. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405

SKELTON, MARVIN E. 11 ACT R
5223 PAULSEN ST., SAV. 31405

SMITH, CARL A. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405

SMITH, H. M. 11 ACT FP
3 MEDICAL ARTS CENTER, SAVANNAH 31405

SOWELL, RAYMOND H., JR. 11 ACT P
615 ROSWELL RD., N.E., MARIETTA 30060

SPERIOSU, S. U. 11 ACT P
1202 BRIGHTWOOD DR., SAVANNAH 31406

STONE, R. L. 11 ACT ANES
5737 COLONIAL DRIVE, SAVANNAH 31406

STRAIGHT, GEORGE W. 11 ACT SU
319 E. HALL STREET, SAVANNAH 31401

STUBBS, JOSEPH T., JR. 11 ACT OPH
720 E. 71ST ST., SAVANNAH 31405

SU, SHAW C. T. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405

SUMMERS, ROLAND S. 11 ACT I
P.O. BOX 5086, SAVANNAH 31403

SUTLIVE, WM. G. 11 ACT OBG
120 E. 34TH ST., SAVANNAH 31401

TANNER, DAVID E. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405

TILLINGER, ARNOLD J. 11 ACT P
515 E. 63RD ST., SAVANNAH 31405

TORRES, SAMUEL A. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405

TRAIN, JOHN KIRK, JR. 11 ACT ALR
1107 BULL ST., SAVANNAH 31401

USHER, CHARLES JR. 11 ACT NS
6 E. LIBERTY ST., SAVANNAH 31401

VALBUENA, O. A. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405

VICTOR, IRVING 11 ACT U
P.O. BOX 6555, SAVANNAH 31405

VICTOR, JULES, JR. 11 ACT I
P. O. BOX 6336, SAVANNAH 31405

WADE, JOHN S. 11 ACT SU
122 E. GASTON ST., SAVANNAH 31401

WALLACE, STUART M. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403

WALLER, JAMES T. 11 ACT I
P. O. BOX 6688, STAT. C, SAVANNAH 31405

WEBB, RAY D. 11 ACT FP
SPRINGFIELD 31329

WEST, JOHN H. 11 ACT I
P.O. BOX 13626, SAVANNAH 31406

WESTERFIELD, C. W. 11 ACT ANES
801 GOEBEL AVE., SAVANNAH 31404

WHELAN, EDWARD J. 11 ACT U
2113 BULL STREET, SAVANNAH 31401

WHIDDON, C. MAURICE 11 ACT SU
122 E. GASTON ST., SAVANNAH 31404

WHITECOTTEN, GLENN L. 11 ACT U
P.O. BOX 3458, SAVANNAH 31403

WILDEY, ROY A. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405

WILKES, LESLIE L. 11 ACT OR
44 MEDICAL ARTS, SAVANNAH 31405

WILLIAMS, A. F. 11 ACT I
423 BULL ST., SAVANNAH 31401

WILLIAMS, C. J. 11 ACT I
P. O. BOX 6167, SAVANNAH 31405

WILLOUGHBY, DAN H. 11 ACT I
2 MIDTOWN MEDICAL CENTER, SAVANNAH 31401

WILLS, BENJAMIN C. 11 ACT PN
835 E. 65TH ST., SAVANNAH 31405

WILSON, ROY G. 11 ACT PL
5105 PAULSEN ST., SAVANNAH 31405

WILSON, W. O. 11 ACT SU
111 E. JONES ST., SAVANNAH 31401

WINBURN, JAMES R., JR. 11 ACT SU
40 MED. ARTS BLDG., SAVANNAH 31405

WIRTH, FREMONT P. 11 ACT N
22 MEDICAL ARTS CENTER, SAVANNAH 31405

WITHINGTON, JOHN C. 11 ACT I
1801 ABERCORN ST., SAVANNAH 31401

WOLFE, WILLIAM W., JR. 11 ACT P
515 E. 63RD ST., SAVANNAH 31405

WRIGHT, DONALD A. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401

YEH, JUI-TING THOMAS 11 ACT TS
5112 PAULSEN ST., SAVANNAH 31405

YOUNG, ZELNAR C. 11 ACT FP
28 MEDICAL ARTS CENTER, SAVANNAH 31405

ZIRKLE, JOHN G. 11 ACT SU
14 MEDICAL ART CENTER, SAVANNAH 31405

12—ELBERT

ARNOLD, MCALPIN H. 12 ACT FP
46 LAUREL DR., ELBERTON 30635

CAMPBELL, HAROLD EUGENE 12 ACT FP
46 LAUREL AVENUE, ELBERTON 30635

HANKS, JACK B. 12 ACT FP
33 CHESTNUT STREET, ELBERTON 30635

JOHNSON, A. S., SR. 12 DES OALR
46 LAUREL DR., ELBERTON 30635

JOHNSON, A. S., JR. 12 ACT FP
LAUREL DR., ELBERTON 30635

MICKEL, CAREY A., JR. 12 ACT SU
35-7 CHESTNUT ST., ELBERTON 30635

ONEAL, JOHN B., III 12 ACT SU
33 CHESTNUT ST., ELBERTON 30635

ONEAL, PHYLLIS J. 12 ACT I
33 CHESTNUT ST., ELBERTON 30635

13—CHATTAHOOCHEE (Forsyth, Gwinnett)

BAGHERI, M.T. 13 ACT TS
14 GWINNETT DR., LAWRENCEVILLE 30245

BOTTOMS, WM. R. 13 ACT FP
601 US HWY 19N, CUMMING 30130

BRAMBLETT, RUPERT H. 13 ACT FP
326 OAKLONEGA RD., CUMMING 30130

COLLINS, LEWIS R. 13 TI
P. O. BOX 609, NEWNAN 30263

DOVE, DONALD V. 13 ACT
44 S. CLAYTON ST., LAWRENCEVILLE 30245

DUNN, WM. R. 13 ACT
P. O. BOX 668, CUMMING 30130

EZZARD, GEORGE P. 13 ACT FP
CROGAN ST., LAWRENCEVILLE 30245

HAMILTON, THOMAS E. 13 ACT FP
1106 DULUTH HWY., N.W.,LAWRENCEVILLE 30245

HARRIS, STERLING A. 13 ACT
DOCTORS BUILDING, BUFORD 30518

HUNT, JAMES 13 ACT FP
P. O. BOX 398, DULUTH 30136

KELLEY, O. C. 13 DES FP
435 PERRY ST., S.W., LAWRENCEVILLE 30245

KENNEDY, THOMAS E. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518

MARCHMAN, MARVIN L. 13 ACT FP
1000 S. BUFORD HWY., NORCROSS 30071

MARTIN, DAN ALLEN 13 ACT SU
P. O. BOX 347, LAWRENCEVILLE 30245

MASHBURN, JAMES S. 13 ACT SL
P. O. BOX 668, CUMMING 30130

MASHBURN, MARCUS 13 DES FP
P. O. BOX 668, CUMMING 30130

MASHBURN, MARCUS, JR. 13 ACT OBG
P. O. BOX 668, CUMMING 30130

MASON, M. H. 13 ACT FP
DULUTH 30136

MAULDIN, JOHN W. 13 ACT FP
1081 29 HWY. S., LAWRENCEVILLE 30245

MILLER, CECIL L. 13 ACT
BUFORD MEDICAL CLINIC, BUFORD 30518

MYERS, ALBERT A. 13 ACT FP
51 S. PTREE ST., NORCROSS 30771

PARRISH, WILLIAM C. 13 ACT FP
160 N. MAIN ST., ALPHARETTA 30201

RAWLINS, GEORGE M. 13 ACT FP
NO CURRENT ADDRESS

SIMS, FAYETTE A., JR. 13 ACT
LAWRENCEVILLE 30245

TEAL, C. B., JR. 13 DES I
HALL CTY. HLTH DEPT., BOX 1295, GAIN 30501

TOOTLE, GEORGE S. 13 ACT SU
DULUTH 30136

TOOTLE, JERRY C. 13 ACT SL
P.O. BOX 746, DULUTH 30136

WAGES, TOM L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518

WEISMAN, H. JAY 13 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

14—CHEROKEE-PICKENS

ALABANZA, F. V. 14 ACT OBG
CANTON MED. CTR., CANTON 30114

ANDREWS, CHAS. R., JR. 14 ACT SU
CANTON 30114

BOODY, A. EVAN 14 ACT
WOODSTOCK 30188

BOSWELL, T. C. 14 ACT FP
TATE 30177

CAUBLE, JOHN A. 14 ACT
P. O. BOX 1048, CANTON 30114

COKER, GRADY N. 14 DES SU
CANTON 30114

CUTTS, WILLIAM G., JR. 14 ACT SU
CANTON MED. CTR., CANTON 30114

DARNELL, D. T. 14 ACT FP
TATE 30177

FIELD, DAVID E. 14 ACT FP
CANTON MED. CTR., CANTON 30114

FLINT, LUCIEN A. 14 ACT R
R. T. JONES MEM. HOSP., CANTON 30114

GOLD, HOMER LECIL, JR. 14 ACT FP
200 MARIETTA ST., CANTON 30114

GONZALEZ, FRANCISCO E. 14 ACT OBG
CANTON MEDICAL CENTER, CANTON 30114

HENDRIX, ARTHUR M. 14 ACT FP
CANTON 30114

JORDAN, CHARLES G. 14 ACT FP
TATE CLINIC, TATE 3D177

LOOPER, BEN KEITH 14 ACT OBG
CANTON 3D114

MATHIS, ERNEST H. 14 ACT OBG
CANTON MED. CTR., CANTON 3D114

NICHOLS, W. H. 14 ACT
CANTON 3D114

PARMER, KEITH M. 14 ACT FP
CANTON MED. CTR., CANTON 30114

PERROW, G. H. 14 ACT FP
JASPER 3D143

ROPER, C. J. 14 ACT SU
JASPER 3D143

ROPER, E. A. 14 ACT FP
JASPER 3D143

SERGENT, PAUL M. 14 ACT FP
200 MARIETTA ST., CANTON 3D114

WILBUR, OSCAR M., JR. 14 ACT PATH
302 W. MAIN ST., CARTERSVILLE 3D120

15—CRAWFORD W. LONG (Clarke, Madison, Oconee, Oglethorpe)

ALLEN, JOHN J. 15 ACT FP
P.O. BOX 6124., ATHENS 3D6D1

BARROW, BEN C. 15 ACT FP
946 PRINCE AVE., ATHENS 306D1

BEALL, JAMES F. 15 ACT P
70D OGLETHORPE AVE., ATHENS 3D601

BERGER, ISRAEL REUBEN 15 ACT R
1010 PRINCE AVENUE, ATHENS 3D6D1

BONNER, WILLIAM H. 15 ACT PD
740 PRINCE AVE., ATHENS 30601

BOWEN, WILLIAM L., JR. 15 ACT OBG
1010 PRINCE AVE., ATHENS 3D601

BOYD, AUGUSTUS B. 15 ACT ANES
P. O. BOX 1732, ATHENS 3D601

BRANYON, DONALD L., JR. 15 ACT OBG
1D10 PRINCE AVE., ATHENS 3D601

BROWN, WALTER J., JR. 15 ACT I
UNIV HEALTH SERVICE, ATHENS 3D602

BRYANT, C. H. 15 DE5 FP
COMER 30629

BURRELL, ZEB, JR. 15 ACT I
ATHENS GENERAL HOSP., ATHENS 30601

CABANISS, W. HARVEY, JR. 15 ACT D
1010 PRINCE AVENUE, ATHENS 3D6D1

CALOWELL, KENDALL W. 15 ACT R
797 COBB ST., ATHENS 3D6D1

CASKIN, CLINTON R.J., JR. 15 ACT U
245 WESTVIEW DR., ATHENS 30601

CLARK, NILE R. 15 ACT FP
1160 PRINCE AVE., ATHENS 3D6D1

CLAY, JAMES R. 15 ACT PATH
ATHENS GENERAL HOSPITAL, ATHENS 3D6D1

COHENOUR, JEFFREY H. 15 ACT PATH
RT. 1-136 BOLTON ST., MONROE 3D655

COHEN, LARRY 15 ACT R
33 SW UPPER RIVERDALE RD., RIVERDALE 3D274

CREAGH, GERARD B. 15 DE1 PH
555 MILLEDGE CIR., ATHENS 30601

CROSBY, WILLIAM V. 15 ACT OBG
740 PRINCE AVE., ATHENS 3D601

CURTIS, JOHN R. 15 ACT P
UNIV. HEALTH SERV., ATHENS 30601

DEMPSEY, JAMES E. 15 ACT OTO
1010 PRINCE AVE., ATHENS 3D601

DIXON, ELLIS F., JR. 15 ACT OBG
1010 PRINCE AVENUE, ATHENS 30601

DUBOSE, BOLLING S., JR. 15 ACT I
225 S. MILLEDGE, ATHENS 3D601

ERWIN, GEORGE 15 ACT PD
1010 PRINCE AVENUE, ATHENS 3D6D1

ERWIN, GOODLOE Y. 15 ACT I
1010 PRINCE AVE., ATHENS 3D601

EYRAS, THOMAS E. 15 DE1 FP
208 CT. ST., VERMILLION, S.D. 57069

FLORENCE, LOREE 15 DE5 PD
P. O. BOX 682, ATHENS 30601

FORD, HENRY J. 15 ACT P
1010 PRINCE AVE., ATHENS 30601

GALLIS, ANTHONY H. 15 ACT I
1D1D PRINCE AVE., ATHENS 3D601

GARCIA, RUBEN E. 15 ACT FP
101D PRINCE AVE., ATHENS 3D601

GIBSON, TIMOTHY B. 15 ACT FP
WINTERVILLE 306B3

GLENN, T. LAMAR 15 ACT I
740 PRINCE AVE., ATHENS 3D601

GOMEZ, ROBERT F. 15 ACT OTO
740 PRINCE AVE., ATHENS 30601

GREEN, DONARELL R., JR. 15 A FP
MORTON BLDG., ATHENS 3D601

GREEN, JAMES A. 15 ACT SU
101D PRINCE AVE., ATHENS 306D1

HAMILTON, SANDRA D. 15 ACT ANES
165 DUNWOODY DR., ATHENS 3D6D1

HANNAH, JAMES F. 15 ACT EM
435 PONDERDSA DR., ATHENS 30601

HARDMAN, WILLIAM J. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601

HARRIS, GILBERT D. 15 ACT FP
B5D GAINES SCHOOL RD., ATHENS 3D601

HASTON, HUGH B., JR. 15 ACT OR
125 KING AVE., ATHENS 30601

HERRIN, E. V. 15 ACT OBG
74D PRINCE AVE., ATHENS 306D1

HILL, JOHN B. 15 ACT OBG
740 PRINCE AVENUE, ATHENS 30601

HINTON, GOLDEN S. 15 ACT OPH
22D N. MILLEDGE AVE., ATHENS 3D6D1

HOLBROOK, WILLIAM H., JR. 15 ACT FP
797 COBB ST., ATHENS G. HOS., ATHENS 3D601

HUBERT, M. A. 15 DE5 U
466 HIGHLAND AVE., ATHENS 30601

HUNNICUT, J. A. 15 DE5 FP
107D S. MILLEDGE, ATHENS 3D6D1

JARRELL, ROBERT J. 15 ACT R
ATHENS GENERAL HOSP., ATHENS 3D6D1

JARRELL, SHELBY E. 15 ACT EM
1230 BAXTER ST., ATHENS 3D601

JOHNSON, NORMAN, JR. 15 ACT PD
1010 PRINCE AVE., ATHENS 306D1

KEITH, W. PERRY 15 ACT EM
P.O. BOX 5B9B, ATHENS 3D6D1

KELLER, A. PAUL, JR. 15 ACT OALR
101D PRINCE AVE., ATHENS 3D6D1

KELLEY, ROBERT E., JR. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601

KING, STEPHEN H. 15 S I
NO CURRENT ADDRESS

KITCHENS, WM. C. 15 ACT I
74D PRINCE AVE., ATHENS 3D6D1

KWON, OH BONG 15 ACT PD
1010 PRINCE AVE., ATHENS 3D6D1

LEWIS, EDWARD L., JR. 15 ACT O
1077 BAXTER ST., ATHENS 3D6D1

MAXWELL, JAMES W. 15 ACT PD
1010 PRINCE AVE., ATHENS 3D6D1

MCDONALD, J. J. 15 ACT SU
740 PRINCE AVE., ATHENS 3D6D1

MCELHANNON, F. M. 15 ACT SU
740 PRINCE AVE., ATHENS 3D601

MCPHERSON, JOHN H. T. 15 ACT SU
1010 PRINCE AVE., ATHENS 30601

MODY, NATWAR J. 15 ACT PATH
797 COBB ST., ATHENS 30601

MONTGOMERY, THOMAS A. 15 ACT SU
1010 PRINCE AVE., ATHENS 3D6D1

MULHERIN, WILLIAM B. 15 ACT OR
125 KING AVE., ATHENS 306D1

MUSE, A. D., JR. 15 ACT SU
740 PRINCE AVE., ATHENS 3D6D1

NEIGHBORS, J. B., JR. 15 ACT I
101D PRINCE AVE., ATHENS 306D1

NEUFELD, JOCELYN R. 15 ACT ANES
135 GATEWOOD PL., ATHENS 30601

NIX, DILLARD L. 15 ACT OALR
1D1D PRINCE AVENUE, ATHENS 30601

PALMER, JACK R. 15 ACT
1010 PRINCE AVE., E. ATHENS 3D6D1

PAYNE, ROBERT A. 15 ACT U
195 KING AVE., ATHENS 3D6D1

RANDOLPH, R. H. 15 ACT SU
740 PRINCE AVE., ATHENS 3D601

READ, SILAS C., JR. 15 ACT OPH
957 BAXTER ST., ATHENS 3D601

SANFORD, SHELTON P. 15 A I
NO CURRENT ADDRESS

SHIFLET, ROBERT E. 15 ACT U
1D10 PRINCE AVE., ATHENS 306D1

SMITH, REUBEN J. 15 ACT OBG
740 PRINCE AVE., ATHENS 3D6D1

STEGEMAN, JOHN F. 15 ACT I
1010 PRINCE AVE., ATHENS 3D601

SWINGLE, ROGER L. 15 ACT OR
125 KING AVE., ATHENS 3D6D1

TALMADGE, HARRY E. 15 ACT SU
489 N. MILLEDGE AVE., ATHENS 3D6D1

THOMASSON, GEORGE O. 15 ACT CH
P. O. BOX B043, ATHENS 306D1

THOMPSON, RAMON C. 15 ACT U
225 S. MILLEDGE, ATHENS 306D1

TILLMAN, BILLUPS P. 15 ACT OR
125 KING AVE., ATHENS 3D6D1

TRAYLOR, JAMES BOTHWELL 15 ACT OBG
74D PRINCE AVE., ATHENS 306D1

TRICE, JOHN C. 15 ACT P
150 TALMADGE DR., ATHENS 3D6D1

TSAO, SHU-YUN T. 15 ACT PD
69B S. MILLEDGE AVE., ATHENS 306D1

TUMLIN, WILLIAM D. 15 ACT FP
LEXINGTON 3D64B

UTLEY, HENRY G. 15 ACT OPH
759 COBB ST., ATHENS 3D6D1

VANDERBURGH, ALEXANDER 15 A FP
517 HAMPTON CT., ATHENS 3D602

WEAVER, RICHARD J. 15 ACT PATH
ST. MARYS HOSP., ATHENS 3D601

WILKINS, JOHN M. 15 ACT ANES
1077 BAXTER ST., ATHENS 3D601

16—CLAYTON-FAYETTE

ABELLERA, E. Q. 16 ACT SU
533D WARRINGTON PL., COLLEGE PK 3D349

ACHECAR, FRED A. 16 ACT NS
33 S.W. UPPER RIVERDALE RD., RIVERDAL 3D274

ALPERT, HAROLD J. 16 ACT U
27BB BAYARD ST., SUITE 103, E POINT 30344

ALONSO, KENNETH B. 16 ACT PATH
CLAYTON GENERAL HOSP., RIVEROALE 3D274

APANAY, MANOLO B. 16 ACT SU
409 ARROWHEAD BLVD., JONESBORO 3D236

ASKEW, JAMES L. 16 ACT R
BOX 21, RIVERDALE 3D274

BUSEY, T. J. 16 DE5 FP
FAYETTEVILLE 3D214

CASTILLO, REUBEN 16 ACT FP
P. O. BOX 157, JONESBORO 3D236

DAVIS, MATTHEW E. 16 ACT OALR
33 S.W. UPPER RVRDALE RD., JONESBORO 3D274

CRAKE, HENRY C. 16 ACT FP
PEACHTREE CITY, 30214

FERNANDEZ, ANDRES P. 16 ACT PATH
1660 BETHHAVEN RD., RIVEROALE 30274

GARFIELD, HERBERT I. 16 ACT PD
217 ARROWHEAD BLVD., JONESBORO 30236

GOMEZ, MIGUEL R. 16 ACT ANES
33 SW UPPER RIVEROALE RD., RIVEROALE 30274

HADLEY, ELIZABETH 16 ACT R
33 UPPER RIVEROALE RD., STE 105, RIV 30274

HARRISON, CLYDE C., JR. 16 ACT
1019 ASTOR AVE., FOREST PARK 30050

HARTLEY, S. T. 16 ACT EM
4614 WINTHROP DR., COLLEGE PK. 30337

HENDRY, CHARLES H. 16 ACT P
33 SW UPPER RIVEROALE RD., RIVEROALE 30274

KUMAR, SUSHIL V. 16 ACT FP
1019 ASTOR AVE., FOREST PARK 30050

LENNON, ROBERT W. 16 ACT OPH
33 SW UPPER RVOLE RD., RIVEROALE 30274

LEYVA, JOSE S. 16 ACT OBG
33 UPPER RIVEROL RD. STE 214 RIVEROL 30274

LUKE, B. O. 16 ACT FP
6103 N. MAIN ST., MORROW 30260

MAYS, ALOINE M., JR. 16 I&R FP
P. O. BOX 598, STOCKBRIDGE 30281

MCDAVID, WILLIAM E., JR. 16 ACT R
P.O. BOX 21, RIVEROALE 30274

MEDINA, LEONARDO H. 16 ACT U
217 ARROWHEAD BLVD., JONESBORO 30236

NAMER, JOSE B. 16 ACT FP&P
259 ARROWHEAD BLVD., JONESBORO 30236

QUILALA, EMILIANO P. 16 ACT FP
409 ARROWHEAD BLVD., JONESBORO 30236

RILEY, WELLS 16 ACT FP
151 WEST MILL, JONESBORO 30236

SAMS, FERROL A., JR. 16 ACT FP
FAYETTEVILLE 30214

SAMS, HELEN F. 16 ACT
FAYETTEVILLE 30214

SOUZA, RENATO C. 16 ACT EM
274 SENOIA RD., FAIRBURN 30213

VIGIL, RAMON A. 16 ACT ANES
33 SW UPPER RIVEROALE RD., RIVEROALE 30274

WERNER, JACQUELINE H. 16 ACT PATH
11 S.W. UPPER RVROALE RD., RVROALE 30274

YU, ALBERT 16 ACT SL
213-B ARROWHEAD BLVD., JONESBORO 30236

YUSUFJI, F. A. 16 ACT OR
33 UPPER RIVEROALE RD., RIVEROALE 30274

ZAKARIA, MAJED S. 16 ACT SL
33 SW UPPER RIVEROALE RD., RIVEROALE 30274

17—COBB (Paulding)

AGRAZ, RODOLFO R. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001

ARANEDA-CASTILLO, E. R. 17 ACT PD
1676 MULKEY RD., AUSTELL 30001

ARIAS, RAMON A. 17 ACT PD
2404 AUSTELL RD., AUSTELL 30001

ARTRESS, GEORGE E. 17 ACT FP
2356 BELMONT CIR., S.E., SMYRNA 30080

ATKINS, MARY T. 17 R PD
173 FOREST DR., SMYRNA 30080

BARNETT, J. C., JR. 17 ACT NS
110 LEWIS DR., N. E., MARIETTA 30060

BARRIOS, RONALDO C. 17 ACT P
3188 ATLANTA ST., S.E., SMYRNA 30080

BEASLEY, CARROLL 17 ACT
50 PLAZA WAY, MARIETTA 30060

BEECHAM, PAUL E. 17 ACT P
11457 HACKETT RD., ROSWELL 30075

BENSON, EARL B. 17 ACT ANES
KENNESTONE HOSPITAL, MARIETTA 30061

BENSON, W. H., JR. 17 ACT I
ROUTE 4, MARIETTA 30060

BETHEA, JAMES S., III 17 ACT OR
1664 W. WESLEY RD., ATLANTA 30327

BLANC, JAMES S. 17 ACT SL
1678 MULKEY RD., AUSTELL 30001

BLOODWORTH, RONALD C. 17 ACT P
3188 ATLANTA ST., S.E., SMYRNA 30080

BLOOM, WALTER L. 17 ACT
225 NORTH AVE., N. W., ATLANTA 30313

BLUMENTHAL, JEROME B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060

BOWER, THOMAS L. R. 17 ACT ANES
705 JUNIPER ST., NE, ATLANTA 30308

BOWLES, F. NORMAN, JR. 17 ACT PATH
3950 AUSTELL RD., AUSTELL 30001

BRALY, SAMUEL U. 17 ACT FP
DALLAS 30132

BROWN, LEONARD 17 ACT O
1416 CHEROKEE STREET, MARIETTA 30062

BROWN, RICHARD M. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060

BURLEIGH, BRUCE O. 17 ACT FP
115 MOORES AVENUE, MARIETTA 30062

BURNS, JAMES B. 17 ACT R
737 CHURCH ST., MARIETTA 30061

BUSSEY, J. G. 17 ACT SL
AUSTELL 30001

BUSSEY, JOSEPH G., JR. 17 ACT SL
5990 LOVE ST., ALSTELL 30001

CAMBLOR, GONZALO 17 ACT PATH
COBB GENERAL HOSP., AUSTELL 30001

CARAS, THOMAS S. 17 ACT I
641 CHURCH ST., MARIETTA 30062

CARROLL, MICHAEL S. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30062

CAUBLE, GEORGE 17 ACT
ACWORTH 30101

CAUSEY, ROBERT S., JR. 17 ACT PD
122 CHERRY ST., MARIETTA 30062

CLABBY, JAMES W. 17 ACT I
1642 MULKEY RD., S.W., AUSTELL 30001

CLARK, F. B. 17 ACT FP
AUSTELL 30001

CLARK, REMER Y., JR. 17 ACT FP
1422 CHEROKEE ST., MARIETTA 30062

CLONTS, W. T. 17 ACT R
70 TOWER RD., MARIETTA 30061

COCHRAN, E. B. 17 ACT SL
641 CHURCH ST., MARIETTA 30060

COGGINS, ROBERT P. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30062

COHEN, RICHARD W. 17 ACT OR
1676 MULKEY RD., AUSTELL 30001

COLQUITT, ALFRED O., JR. 17 ACT OBG
1205 ROSWELL ST., MARIETTA 30062

COLQUITT, ALFRED O., III 17 ACT OR
732 CHEROKEE ST., MARIETTA 30060

COLQUITT, HUGH S. 17 ACT
615 ROSWELL STREET, MARIETTA 30062

COOPER, JAMES T. 17 ACT FP
2480 WINDY HILL RD., MARIETTA 30062

COUSINS, WM. L. 17 ACT I
792 CHURCH ST., MARIETTA 30060

COXWELL, WAYNE L. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001

CRARY, ELY J. 17 ACT OPH
4730 AUSTELL RD., AUSTELL 30001

CRAWFORD, GLENN O. 17 ACT R
COBB GENERAL HOSP., AUSTELL 30001

CURIEL, HECTOR J. 17 ACT FP
MEDICAL BLDG., DALLAS 30132

CURRY, VIRGIL L. 17 ACT U
2404 AUSTELL-MARIETTA RD., AUSTELL 30001

DAVIS, WILKES H., JR. 17 ACT OPH
653 CHEROKEE ST., N. E., MARIETTA 30060

DAVIS, WILLIAM S. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001

DEFOOR, JOSEPH T., JR. 17 ACT ANES
754 CHEROKEE ST., MARIETTA 30060

DELLINGER, RAY E. 17 ACT SL
3001 S. COBB DR., S. E., SMYRNA 30080

DOXEY, CLEM M., JR. 17 ACT O
114 CHERRY ST., SUITE E, MARIETTA 30060

DUBOSE, LIGE MOULTRIE 17 ACT
1205 ROSWELL STREET, MARIETTA 30062

DUNCAN, ROY G. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060

ESPY, GOODMAN B., III 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060

FEINERMAN, LOIS K. 17 ACT O
1680 MULKEY RD., AUSTELL 30001

FEINERMAN, MICHAEL B. 17 ACT PL
1680 MULKEY RD., AUSTELL 30001

FERRIER, FRANK L. 17 ACT TS
754 CHEROKEE, MARIETTA 30060

FLANDERS, CHARLES E., JR. 17 ACT ANES
754 CHEROKEE ST., N.E., MARIETTA 30060

FLETCHER, MELVIN R. 17 ACT PD
122 CHERRY ST., MARIETTA 30060

FORTSON, LUTHER G., JR. 17 ACT I
KENNESTONE HOSP., MARIETTA 30060

FOWLER, R. W., JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060

GALLASTRA, JUAN A. 17 ACT I
1039 RIDGE AVE., ATLANTA 30315

GALLOWAY, GEORGE W., JR. 17 ACT FP
KENNESTONE HOSP., MARIETTA 30060

GARDNER, JOSEPH M. 17 ACT OBG
2404 AUSTELL MARIETTA RD., AUSTELL 30001

GARRETT, LUKE G., JR. 17 ACT
AUSTELL 30001

GERSON, GORDON N. 17 ACT OR
1620 MULKEY RD., AUSTELL 30001

GILLETT, BRUCE M. 17 ACT N
50 PLAZA WAY, MARIETTA 30060

GLOVER, DOUGLAS O. 17 ACT OBG
653 CHEROKEE ST., N.E., MARIETTA 30060

GOLDSTEIN, MARTIN I. 17 ACT O
3001 S. COBB DR., S. E., SMYRNA 30080

GOULD, MARK A. 17 ACT P
3188 ATLANTA ROAD, SMYRNA 30080

GRAHAM, WISTAR L. 17 ACT NS
86 S. COBB DR., MARIETTA 30060

GRANTIER, DAVID R. 17 ACT FP
COBB GENERAL HOSP., AUSTELL 30001

GREEN, RICHARD L. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30062

GRIFFITH, THOMAS H. 17 ACT U
652 CHURCH ST., MARIETTA 30060

HAGOOD, MURL F. 17 ACT SL
660 CHEROKEE ST., MARIETTA 30060

HAGOOD, M. M. 17 ACT SL
50 PLAZA WAY, MARIETTA 30060

HAGOOD, RICHARD M. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001

HALL, GEORGE W. 17 ACT R
3950 AUSTELL RD., AUSTELL 30001

HALL, MAXWELL F., JR. 17 ACT R
70 TOWER RD., MARIETTA 30060

HAMMONDS, RICHARD LEE 17 ACT FP
AUSTELL 30001

HANSON, I. R., JR. 17 A R
3865 STORY DR., MARIETTA 30060

HARBOUR, JOHN H. 17 ACT I
P. O. BOX 1266, SMYRNA 30080

HARLEY, EUGENE L. 17 ACT I
705 CONCORD RD., SMYRNA 30080

HARRISON, GEORGE I. 17 ACT ALR
1416 CHEROKEE ST., MARIETTA 30062

HENDERSON, CHARLES T. 17 ACT SU
521 CAMPBELL HILL ST., MARIETTA 30060

HODGES, JOHN M. 17 ACT SU
805 CAMPBELL ST., MARIETTA 30062

HOLLADAY, WM. EDWARD, JR. 17 ACT
787 CAMPBELL HILL ST., MARIETTA 30062

HUTTENBACH, DIRK E. 17 ACT P
627 CHEROKEE ST., N.E., MARIETTA 30060

INGLIS, E. P., JR. 17 ACT
1308 CHURCH STREET, MARIETTA 30062

INSIGNARES, MANUEL S. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001

ISRAEL, PHILIP Z. 17 ACT SU
3001 S. COBB DR., S. E., SMYRNA 30080

JACOBSON, ALAN I. 17 ACT PATH
P. O. BOX 665, MABLETON 30059

JENNINGS, C. M. 17 ACT I
641 CHURCH STREET, MARIETTA 30060

KAISER, RICHARD R. 17 ACT PD
3001 S. COBB DR., S. E., SMYRNA 30080

KELLEHER, ROBERT M. 17 ACT D
114 CHERRY ST., SUITE E, MARIETTA 30060

KIMMERLING, RICHARD W. 17 ACT SU
2404 AUSTELL RD., AUSTELL 30001

KING, OLIVER W. 17 ACT SU
3001 S. COBB DR., SMYRNA 30080

KIRKPATRICK, JAS L., JR. 17 A I
304 N. HILLCREST DR., MARIETTA 30062

KLEBER, RONALD J. 17 ACT P
84 LACY ST., MARIETTA 30060

KLEIMAN, SCOTT G. 17 ACT DR
3910 AUSTELL RD., AUSTELL 30001

KLINGBEIL, ROBERT TAYLOR 17 ACT PM
KENNESTONE HOSP., MARIETTA 30060

KNOX, JOHN D., JR. 17 ACT OR
1416 CHEROKEE ST., MARIETTA 30062

KUSHNAR, ROBERT L., JR. 17 ACT R
3001 S. COBB DR., SMYRNA 30080

KYBURZ, BRUCE A. 17 ACT U
NO CURRENT ADDRESS

LAMBERT, ROBERT Y. 17 ACT SU
2241 LEWIS ST., KENNESAW 30144

LAYNE, WILLIAM T. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001

LESSLIE, WILLIAM P. 17 ACT I
86 S. COBB DR., MARIETTA 30060

LIGON, WALTER M. 17 ACT OTC
444 FAIRGROUND ST., MARIETTA 30062

LINOSEY, MARK M. 17 ACT FP
155 TRAIL POINT, ATLANTA 30338

LORENZ, MAX P. 17 ACT U
652 CHURCH ST., N. E., MARIETTA 30060

LYNDTT, MARJORIE A. 17 ACT FP
277 FAIRGROUND ST., MARIETTA 30062

MAINOR, ROBERT 17 ACT FP
2874 KING ST., S.E., SMYRNA 30080

MANNING, JAMES HUNT 17 ACT SU
50 PLAZA WAY, MARIETTA 30060

MANUS, RICHARD CHESLEY 17 ACT FP
1668 MULKEY RD., AUSTELL 30001

MARKLE, C. DAVID 17 ACT I
2271 AUSTELL RD., AUSTELL 30001

MATHIS, W. H., JR. 17 ACT R
KENNESTONE HOSPITAL, MARIETTA 30061

MAY, ROBERT O. 17 ACT U
50 PLAZA WAY, MARIETTA 30060

MAY, STEPHEN C., JR. 17 ACT FP
SOUTH MAIN STREET, KENNESAW 30144

MCBRIDE, WALTER W. 17 ACT I
52 TOWER RD., MARIETTA 30062

MCCLURE, E. RUTH 17 ACT OBG
805 CAMPBELL HILL ST., MARIETTA 30062

MCGUIRE, JAMES E. 17 ACT OBG
NO CURRENT ADDRESS

MCKINNON, FRANK W. 17 ACT DR
652 CHURCH ST., MARIETTA 30060

MCLEAN, WM. R. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060

MEADERS, HENRY D. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060

MEADOWS, NOAH D., JR. 17 ACT I
52 TOWER RD., MARIETTA 30060

MIHALOUITS, KARL S. 17 ACT P
3188 ATLANTA ST., SMYRNA 30080

MIMS, GEO. T., JR. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30062

MITCHELL, MARVIN M. 17 ACT OR
3910 AUSTELL RD., AUSTELL 30001

MITCHELL, P. ROBERT 17 ACT OBG
653 CHEROKEE ST. N.E., MARIETTA 30060

MITCHELL, W. C. 17 ACT FP
SMYRNA 30080

MULLINIKS, ROBERT C., JR. 17 ACT OBG
2404 AUSTELL RD., AUSTELL 30001

MULLINS, SPENCER G. 17 ACT SU
605 CAMPBELL HILL ST., MARIETTA 30062

MURRAY, DARRELL W. 17 ACT FP
355 OLO POWDER SPRINGS RD, MABLETON 30059

MUSARRA, E. A. 17 ACT FP
220 CHURCH ST., MARIETTA 30060

MUSSER, ELLYN Z. 17 ACT PD
277 PAT MELL RD., S.E., MARIETTA 30060

NANCE, DANA W. 17 ACT SU
142 COUNTRY CLUB DR.,NEW ORLEANS, LA 70124

NAZLI, MEHMET H. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001

NICHOLS, EVANS J. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060

NUTTALL, ROBERT P. 17 ACT FP
123 GORDON RD., MABLETON 30059

OKUN, PHILIP 17 I&R P
NO CURRENT ADDRESS

PALMER, J. GARY, JR. 17 ACT U
823 CAMPBELL HILL ST., MARIETTA 30060

PARHAM, ROBERT E. 17 ACT N
670 CHEROKEE ST., N.E., MARIETTA 30060

PARKER, PRENTISS E., JR. 17 ACT OBG
3001 S. COBB DR., SMYRNA 30080

PATTERSON, WM. C. 17 ACT SU
3903 S. COBB DR., SUITE 110, SMYRNA 30080

PAUSA, SERGIO G. 17 ACT SU
123 GORDON RD., MABLETON 30059

PAYNE, PAUL J. 17 ACT DR
652 CHURCH ST., MARIETTA 30060

PENA, LEOPOLD I. 17 ACT SU
3812 AUSTELL RD., MARIETTA 30060

PENNINGTON, JOHN A. 17 ACT ANES
3312 BUNKER HILL DR., MARIETTA 30062

PHILLIPS, JOE M., JR. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060

PORTER, HARRY, JR. 17 ACT P
3188 ATLANTA RD., S.E., SMYRNA 30080

PRINCE, ALAN D. 17 ACT N
50 PLAZA WAY, MARIETTA 30060

PROCHNICKI, LOUIS J. 17 ACT OBG
3910 AUSTELL RD., AUSTELL 30001

RAGAN, KENNETH D. 17 ACT P
84 LACY ST., MARIETTA 30060

RANDALL, ALFRED H., JR. 17 ACT I
641 CHURCH ST., MARIETTA 30060

RE, PETER K. 17 ACT N
50 PLAZA WAY, SUITE B, MARIETTA 30060

REILLY, ENOS J. 17 ACT OBG
513 CAMPBELL HILL, MARIETTA 30060

REY, CHARLES J., JR. 17 ACT SU
4399 AUSTELL RD., AUSTELL 30001

ROBBINS, ROBERT C. 17 ACT I
52 TOWER RD., N. W., MARIETTA 30062

ROBERTS, STEWART R., JR. 17 A R
80 BUTLER ST., S.E., ATLANTA 30303

ROONEY, DONALD R. 17 ACT R
70 TOWER RD., N.W., MARIETTA 30060

ROSE, A. MCKOY, JR. 17 ACT SU
1416 CHEROKEE ST., MARIETTA 30062

ROSEN, RONALD 17 ACT U
1620 AUSTELL RD., AUSTELL 30001

SANDBERG, JOHN 17 ACT
KING-WILLIAMS BLDG., SMYRNA 30080

SANDERS, GERALD E. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060

SAYE, WILLIAM B. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060

SCHMIDT, F. K. 17 ACT U
823 CAMPBELL HILL ST., MARIETTA 30060

SELMONOSKY, CARLOS A. 17 ACT TS
1678 MULKEY RD., AUSTELL 30001

SESSIONS, ROBERT T. 17 ACT SU
811 CHURCH ST., MARIETTA 30062

SHAPIRO, STANLEY T. 17 ACT OTO
2550 ATLANTA RD., SMYRNA 30080

SHERRER, WEBSTER A. 17 ACT PATH
KENNESTONE HOSPITAL, MARIETTA 30061

SHUMAN, ROBERT CHARLES 17 ACT ANES
LEWIS DRIVE, MARIETTA 30060

SIGAL, HOWARD MARVIN 17 ACT PD
1001 S. COBB DRIVE, SMYRNA 30080

SMITH, DARIUS A. 17 ACT FP
MEDICAL BLDG., DALLAS 30132

SMITH, SAMUEL R. 17 ACT ANES
673 STEWART AVE., N. W., MARIETTA 30060

SOMERLOT, WARREN A. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060

SPROUSE, JAMES H., JR. 17 ACT ANES
754 CHEROKEE ST., MARIETTA 30060

STALEY, IRVING T. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060

STANCIL, MELDOY ANN 17 ACT ANES
1805 ROSWELL RD., APT. 3-F, MARIETTA 30060

STAPLETON, GERALD M. 17 ACT OTC
2550 WINDY HILL ROAD, MARIETTA 30060

STARR, DONALD C. 17 ACT R
KENNESTONE HOSP., RADIOLOGY,MARIETTA 30060

STEPHENS, DAN B. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060

STEPHENS, ROBERT O. 17 ACT PD
680 CHURCH ST., MARIETTA 30060

STONE, JOHN R. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060

STURKIE, THOMAS OTIS 17 ACT DR
652 CHURCH ST., MARIETTA 30060

SWIFT, JONATHAN S. 17 ACT DR
1422 CHEROKEE STREET, MARIETTA 30062

TABATABAI, JAFAR 17 ACT PATH
P.O. BOX 665, MABLETON 30059

TANNER, JACK E. 17 ACT DBG
1200 ROSWELL RD., MARIETTA 30060

TAYLOR, ROBERT P. 17 ACT OPH
MED. ARTS BLD., ROSWLL ST., MARIETTA 30060

TEEM, M. V. B. 17 ACT I
200 CHEROKEE STREET, MARIETTA 30060

TEEM, MARTIN V., JR. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060

THIBODEAUX, DAVID C. 17 ACT R
70 TOWER RD., N.W., MARIETTA 30062

TILIACOS, JOHN N. 17 ACT DR
104 BEVERLY HILLS DR., MARIETTA 30062

TODLE, JAMES C. 17 ACT DBG
731 SANDTOWN RD., MARIETTA 30060

TOWNSEND, ROBERT M. 17 ACT FP
627 CHEROKEE ST., MARIETTA 30060

TRIPPE, JUDSON R., JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060

TRYON, WM. E. 17 ACT FP
2380 ROSWELL RD., MARIETTA 30062

UNDERWOOD, CHARLES R. 17 ACT
641 CHURCH ST., MARIETTA 30060

VANDERPOOL, GERALD E. 17 ACT AL
6500 VERNON WOODS DR., ATLANTA 30328

VANSANT, T. J., JR. 17 ACT I
P. O. BOX 1287, MARIETTA 30062

VAUGHAN, EDGAR ALLEN 17 ACT
74 MEDICAL SQUARE, MARIETTA 30060

VILLANUEVA, L. S. 17 ACT P
1676 MULKEY RD., AUSTELL 30001

WAKEFIELD, JOHN R. 17 ACT
2404 MARIETTA RD., AUSTELL 30001

WALLACE, BILL L. 17 ACT FP
2480 WINDY HILL RD., ATLANTA 30060

WARD, M. CAROLYN 17 ACT OBG
805 CAMPBELL HILL ST., MARIETTA 30062

WARD, MARY C. 17 ACT PD
652 CHURCH ST., MARIETTA 30060

WARNER, JOHN C., JR. 17 ACT PD
3001 S. COBB DR., S. E., SMYRNA 30080

WARNICK, LILLIAN P. 17 ACT PH
12 CAPITOL SQUARE, NE, ATLANTA 30334

WEISMAN, EVAN B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060

WILHELM, CHARLES C. 17 ACT I
792 CHURCH ST. EXT., MARIETTA 30060

WILLIAMS, MALCOLM H. 17 ACT I
3001 S. COBB DR., SMYRNA 30080

WILLIAMS, WILLIAM TALBERT 17 ACT
705 CONCORD RD., SMYRNA 30080

WOFFORD, BENJAMIN H., JR. 17 ACT PL
644 CHEROKEE ST., MARIETTA 30060

18—COFFEE (Atkinson)

BELL, EUGENE D. 18 ACT
DOUGLAS 31533

BENSON, RICHARD L. 18 ACT R
BOX 1077, DOUGLAS 31533

COGDELL, B. H. 18 ACT FP
ALMA 31510

GILLIARD, FRED E. 18 ACT FP
WARD ST., DOUGLAS 31533

HERNDON, JOHN W. 18 ACT FP
OCILLA RD., DOUGLAS 31533

JARDINE, DAN A. 18 ACT SU
DOUGLAS 31533

MCRAE, A. T. 18 ACT SU
1004 W. WARD ST., DOUGLAS 31533

MEEKS, CALVIN STEWART, JR 18 ACT FP
DOUGLAS 31533

PARKER, T. L. 18 ACT SU
DOUGLAS 31533

RUDOLPH, STEPHEN J., JR. 18 ACT INO
702 N. GASKIN AVE., DOUGLAS 30533

RUSSELL, ROGER K. 18 ACT FP
P.O. BOX 779, PEARSON 31642

STAPLETON, TOMMY K. 18 ACT FP
WESTSIDE DR., DOUGLAS 31533

WHITTLE, MICHAEL R. 18 ACT PATH
COFFEE GEN. HOSP., DOUGLAS 31533

WILLS, WILLIAM R., JR. 18 ACT FP
SHIRLEY AVE., DOUGLAS 31533

19—COLQUITT

ADCOCK, DAVID W. 19 ACT OR
1414 S. MAIN ST., MOULTRIE 31768

CONGER, P. D. 19 ACT FP
MOULTRIE 31768

FLYNN, JAMES T., JR. 19 ACT OALR
MOULTRIE 31768

FOKES, ROBERT E., JR. 19 ACT OALR
MOULTRIE 31768

FUNDERBURKE, A. G. 19 OEI FP
1935-4TH ST., SE, MOULTRIE 31768

GAY, FRANCIS M. 19 ACT FP
MOULTRIE 31768

HARRISON, WALTER E. 19 ACT FP
711 S. MAIN, MOULTRIE 31768

HARVEY, LOUIS R. 19 A PH
P. O. BOX 383, SANDERSVILLE 31083

HARWELL, C. W. 19 A PH
561 CANDLEWOOD DR., ST. MOUNTAIN 30083

HESTER, THOMAS R., JR. 19 ACT SU
S. MAIN ST., MOULTRIE 31768

JOINER, R. M. 19 ACT PD
MOULTRIE 31768

KITCHENS, WILLIAM R. 19 ACT SU
717 COLONIAL VILLAGE, MOULTRIE 31768

LA CONTE, LEONARD P. 19 ACT R
MEMORIAL HOSP., MOULTRIE 31768

MCCOY, JOHN F. 19 ACT FP
MOULTRIE 31768

MCGINTY, W. R. 19 ACT SU
MOULTRIE 31768

MCLEOD, JOHN W. 19 ACT SU
223 S. MAIN ST., MOULTRIE 31768

MOORE, CHARLES R. 19 ACT OPH
1303 FOURTH ST., S.W., MOULTRIE 31768

MURTHY, B. R. KRISHNA 19 ACT I
GRANT PLAZA, MOULTRIE 31768

NEWTON, W. M., JR. 19 ACT I
MED. CTR., THOMASVILLE HWY, MOULTRIE 31768

PAULK, J. R. 19 ACT OALR
P. O. BOX 370, MOULTRIE 31768

ROGERS, EDWARD A., JR. 19 ACT OBG
700 S. MAIN, MOULTRIE 31768

TUCKER, JOHN P. 19 ACT FP
300 13TH AVE., S.W., MOULTRIE 31768

20—COWETA

ARNOLD, J. H. 20 OE1 FP
P. O. BOX 279, NEWNAN 30263

BARRON, WM. E. JR. 20 ACT I
P.O. BOX 609, NEWNAN 30263

BASS, F. DONALD 20 ACT SU
240 JACKSON ST., NEWNAN 30263

BRYANT, JAMES M., JR. 20 ACT
NEWNAN 30263

BURNS, MATTHEW L. 20 ACT SU
15 CAVENDER ST., NEWNAN 30263

FARMER, CHAS. W., JR. 20 ACT OALR
P. O. BOX 609, NEWNAN 30263

FORBIS, SAMUEL E., JR. 20 ACT R
P. O. BOX 997, NEWNAN 30263

GEERKEN, LUIS A. 20 ACT ANES
COWETA GENERAL HOSPITAL, NEWNAN 30263

GILBERT, FREDERICK E. 20 ACT PATH
COWETA GENERAL HOSP., NEWNAN 30263

GLOVER, HOWARD C., JR. 20 ACT PD
NEWNAN 30263

GLOVER, N. B. 20 ACT PD
NEWNAN 30263

GRAHAM, THOMAS C. 20 ACT OBG
P. O. BOX 609, NEWNAN 30263

HANNA, MICHAEL B. 20 ACT OPH
85 ACKSON ST., NEWNAN 30263

JARRARD, GEORGE T. 20 ACT I
P. O. BOX 609, NEWNAN 30263

JENKINS, BEN F. 20 ACT OALR
P. O. BOX 1120, NEWNAN 30263

JOHNSON, MARGARET W. 20 ACT PATH
P. O. BOX 20262, BIRMINGHAM, ALA 35216

MACNABB, GEORGE M. 20 ACT I
P.O. BOX 609, NEWNAN 30263

MANGET, FRED P. 20 OE5
3372 OSBORNE PL., MACON 31204

MCDONALD, R. F. 20 OE5 SU
P. O. BOX 933, NEWNAN 30263

MIKELL, JOEL E. 20 ACT R
COWETA GEN. HOSP., NEWNAN 30263

PARKS, JOSEPH W., JR. 20 ACT FP
P. O. BOX 609, NEWNAN 30263

POWELL, JACK H., JR. 20 ACT SU
P.O. BOX 609, NEWNAN 30263

SOSBY, JOHN T. 20 ACT OBG
P. O. BOX 609, NEWNAN 30263

THOMASSON, JAMES J., JR. 20 ACT SU
P.O. BOX 609, NEWNAN 30263

WELLS, JOHN G. 20 ACT I
P.O. BOX 1099, NEWNAN 30263

21—DECATUR-SEMINOLE

BELLVILLE, CHAS. GEORGE 21 ACT SU
BAINBRIDGE 31717

BRECKENRIDGE, H. E., JR. 21 ACT FP
HOSPITAL CIRCLE, DONALSONVILLE 31745

CARPENTER, R. S. 21 ACT SU
1607-A E. SHOTWELL ST., BAINBRIDGE 31717

EHRLICH, M.A. 21 OE5 PD
231 E. BROUGHTON ST., BAINBRIDGE 31717

GIBSON, FRANK L. 21 ACT SU
BAINBRIDGE 31717

HOLLEY, JACOB H. 21 ACT FP
DONALSONVILLE 31745

MCNAIR, HAL 21 ACT FP
1500 E. SHOTWELL, BAINBRIDGE 31717

REYNOLDS, MILTON B., JR. 21 ACT FP
DONALSONVILLE CLINIC, DONALSONVILLE 31745

STARLING, ROBERT L. 21 ACT FP
MOSELEY CLINIC, DONALSONVILLE 31745

STEWART, CHARLES C. 21 ACT FP
P.O. BOX 371, DONALSONVILLE 31745

WALKER, CHARLES O. 21 ACT SU
SEMINOLE MEM. HOSP., DONALSONVILLE 31745

WILLIS, LEO W. 21 ACT FP
P.O. BOX 915, BAINBRIDGE 31717

WOODS, E. ASHBY 21 ACT FP
BAINBRIDGE 31717

ZILIS, JAMES J. 21 ACT OBG
P.O. BOX 933, BAINBRIDGE 31717

22—DeKALB

ACKERMAN, ELLIOTT A. 22 ACT CR
365 WINN WAY, DECATUR 30030

ADAN, ANIBAL 22 ACT ANES
P.O. BOX 33247., DECATUR 30033

ALDRIDGE, STANLEY P. 22 ACT I
755 COLUMBIA DR., DECATUR 30030

ALLARD, CHARLES 22 ACT SU
755 COLUMBIA DR., DECATUR 30030

ALLEN, H. H. 22 OE5 FP
2343 HENDERSON MILL RD., ATLANTA 30342

ALLEN, LEE T. 22 ACT U
755 COLUMBIA DR., DECATUR 30030

ALPERN, ROBERT J. 22 ACT CHLD
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

AMATRIAIN, F. F. 22 ACT OBG
340 BOULEVARD, N.E., ATLANTA 30312

ANTHONY, JAMES E., JR. 22 ACT SU
755 COLUMBIA DR., DECATUR 30030

ARNOLD, J. A. 22 ACT FP
2170 BRIARCLIFF RD. N.E., ATLANTA 30329

ARNOVITZ, GERSON H. 22 ACT PD
2714 CLAIRMONT RD., N.E., ATLANTA 30329

ARTIME, MANUEL E. 22 ACT AL
1275 MCCONNELL DR., DECATUR 30033

ATKINS, EARNEST C. 22 ACT SU
2910 N. DRUID HILLS RD., ATLANTA 30329

AVRET, EDWIN T. 22 ACT I
3290 MEMORIAL DR., DECATUR 30032

BALL, HORACE C. 22 ACT OBG
231 E. PONCE DE LEON, DECATUR 30030

BARIA, WILLIAM F. 22 ACT I
2895 N. DRUID HILLS RD., N.E., ATL. 30329

BARTON, EARL C., JR. 22 ACT PATH
2701 N. DECATUP RC., DECATUR 30030

BELCHER, WILLIAM T., JR. 22 ACT OPH
2754 N. OECATUR RD., DECATUR 30033

BILLIPS, WILLIAM C. 22 ACT DPH
3576 CHAMBLEE TUCKER RD., ATLANTA 30341

BLACK, PAUL W. 22 ACT PL
960 JOHNSON FERRY RO., N.E., ATLANTA 30342

BLACKSTON, RONALD O. 22 ACT PO
1365 CLIFTON PD., N.E., ATLANTA 30322

BLAIR, H. DUANE 22 ACT SU
755 COLUMBIA CP., OECATUR 30030

BOBO, W. EARL 22 ACT SU
365 WINN WAY, DECATUR 30030

BOWCOCK, JAMES Z. 22 ACT P
755 COLUMBIA CR., OECATUR 30030

BRANAN, WM. J., JR. 22 ACT PO
1989 N. WILLIAMSBURG OR., DECATUR 30033

BRANNEN, JAMES O. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033

BREIBANT, SIONEY 22 ACT PD
11 LAVISTA PER. OFC. PK., TUCKER 30084

BRICE, ANTON, JR. 22 ACT I
542 CHURCH ST., DECATUR 30030

BRDOKS, BETTY ANN 22 ACT OBG
365 WINN WAY, DECATUR 30030

BROOKS, COURTNEY C. 22 ACT FP
2223 CANDLER ROAD, DECATUR 30032

BROWNE, THOMAS MORGAN 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345

BUCHANAN, L. C. 22 ACT SU
374 W. PONCE DE LEON AVE., DECATUP 30030

BURNETT, STACY W. 22 ACT PD
2100 PARKLAKE DR., N.E., ATLANTA 30345

BUTTERWORTH, HENRY H. 22 ACT I
603 CHURCH STREET, DECATUR 30030

CARTER, LEON, JR. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030

CASTLE, JOHN RICHARD 22 ACT OBG
231 E. PONCE DE LEON AVE., DECATUR 30030

CHANG, LUNG-HSIUNG 22 ACT OPH
1300 W. PIKE PL., LAWRENCEVILLE 30245

CHANNA, G. H. 22 ACT PD
4705 LAWRENCEVILLE HWY., LILBURN 30247

CHRISTOPHER, PHILIP E. 22 ACT SU
365 WINN WAY, DECATUR 30032

CODINGTON, ARTHUR B. 22 ACT I
2644 CANDLER PKWY., DECATUR 30032

COFFSKY, JAY S. 22 ACT R
755 COLUMBIA DR., DECATUR 30030

COLVIN, RICHARD S. 22 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322

CONNER, WILLIAM C. 22 ACT P
755 COLUMBIA DR., DECATUR 30030

COOPER, JERRY L. 22 ACT
3300 MEMORIAL DR., DECATUR 30033

COTTS, LEONARD L. 22 ACT I
364B CHAMBLEE TUCKER RD., ATLANTA 30341

CRANK, R. PAUL 22 ACT I
755 COLUMBIA CR., DECATUR 30030

CRANMAN, JERARD S. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033

CRISPIN, ROY F. 22 ACT TS
365 WINN WAY, DECATUR 30030

DALY, FRANK T., JR. 22 ACT R
755 COLUMBIA OR., DECATUR 30030

DAVIES, ROBERT L. 22 ACT R
755 COLUMBIA CR., DECATUR 30030

DIXON, JOHN M. 22 ACT OPH
12 LAVISTA PER. OFF. PK., TUCKER 30084

DRESSLEP, MARIAN S. 22 DE2 PH
777 HOUSTON MILL RO., N.E., 5, ATL 30329

DUARTE, CARLOS R. 22 ACT PD
365 WINN WAY, DECATUR 30030

DULL, MARTHA KATHERINE 22 ACT OBG
4330 LAVISTA RO., TUCKER 30084

DUNCAN, G. A. 22 OE5 FP
714 S. CANDLER STREET, DECATUR 30030

DUNN, BYRON H. 22 ACT OBG
2910 N. DRUID HILLS RD., ATLANTA 30329

EARLE, WALTER C. 22 OE5
2750 REDDING RO., N. E., ATLANTA 30319

EAVES, ROBERT F., JR. 22 ACT
2390 MAIN ST., TUCKER 30084

EDWARDS, F. KATHERINE 22 ACT R
4777 REBEL TRAIL, N.W., ATLANTA 30327

EDWARDS, PHILIP D. 22 ACT L
960 JOHNSON FRY. RD., STE 420, AT 30342

EIDEX, MARSHALL F. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033

EIDEX, MAXWELL A. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033

EITH, RONALD E. 22 ACT AL
4511 CHAMBLEE DUNWOODY RO., ATLANTA 30341

ELLZEY, B. FRANK 22 ACT OBG
340 BOULEVARD, N. E., ATLANTA 30312

ELLZEY, MILDRED JANE 22 ACT PD
3290 MEMORIAL DR., DECATUR 30032

ESTES, J. W. 22 ACT VS
353 PARKWAY DP., N.E., ATLANTA 30312

EVANS, J. RUFUS 22 OE5 FP
STONE MOUNTAIN 30083

FEINGOLD, ALAN O. 22 A I
1365 CLIFTON RD., N.E., ATLANTA 30322

FERNANDEZ, EZEQUIEL P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

FILAROI, GERALD A. 22 ACT U
755 COLUMBIA CP., DECATUR 30030

FINE, ROBT. M. 22 ACT D
755 COLUMBIA OR., OECATUR 30030

FISHMAN, LEONARD 22 ACT D
2754 N. DECATUR RD., DECATUR 30033

FITE, J. DONALD 22 ACT OPH
542 CHURCH ST., DECATUR 30030

FLEMING, SIONEY H. 22 ACT P
1256 BRIARCLIFF RD., N. E., ATLANTA 30306

FOKES, ERNEST C. 22 ACT NS
365 WINN WAY, DECATUR 30030

FOSTER, CATHERINE E. 22 ACT OBG
924 W. SPRING ST., MONROE 30655

FOSTER, H. R. 22 ACT PD
7660 COVINGTON HWY., LITHONIA 30058

FREEMAN, LAWRENCE L. 22 ACT
3652 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

FREGOSI, ALBERT H. 22 ACT U
755 COLUMBIA CR., DECATUR 30030

FRISTOE, JOHN W., JR. 22 ACT OBG
1551 MASON MILL RD., NE, ATLANTA 30329

FUERST, JULIAN F. 22 ACT OBG
755 COLUMBIA DR., DECATUR 30030

GALLER, EDWIN J. 22 ACT I
2054-G LAWRENCEVILLE HWY, DECATUR 30033

GANN, JOYCE A. 22 ACT OBG
365 WINN WAY, DECATUR 30030

GIBBS, R. I., JR. 22 ACT I
2193 N. DECATUP RD., DECATUR 30033

GIRARDEAU, HERBERT S., JR 22 ACT SU
1270 MCCONNELL DR., DECATUR 30033

GRANT, R. PERRY 22 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

GRAY, JAMES R. 22 A PD
69 BUTLER ST., S.E., ATLANTA 30303

GRAY, SAMUEL F. 22 ACT SU
4556 N. SHALLOWFORD RD., ATLANTA 30341

GRIFFIN, JOHN B., JR. 22 ACT P
1365 CLIFTON RD., N. E., ATLANTA 30322

HARDCASTLE, WILLIAM R. 22 ACT SU
9 LAVISTA PERIMETER OFC. PK., TUCKER 30084

HARDEN, TIMOTHY, JR. 22 ACT I
711 CHURCH STREET, DECATUR 30030

HARDY, WALLACE E. 22 ACT OBG
5 LAVISTA PERIMETER PARK, TUCKER 30084

HARRISON, JOHN R. 22 ACT
5372 PEACHTREE RO., CHAMBLEE 30341

HATFIELD, HUGH A. 22 ACT FP
2064 PEACHTREE INDUSTRIAL CT., CHAMBLEE 30341

HEARD, JOHN P. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030

HOOSE, KENNETH A., JR. 22 ACT I
1276 MCCONNELL DR., DECATUR 30033

HOOSE, ELOON E. 22 ACT FP
3644 CHAMBLEE TUCKER RD., CHAMBLEE 30341

HOWELL, EDGAR V., JR. 22 ACT OR
755 COLUMBIA DR., DECATUR 30030

HUBBELL, ROBT. W. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033

HUFF, PRENTIS BAKER 22 ACT OR
755 COLUMBIA DR., DECATUR 30030

JANTER, THOMAS B. 22 ACT PD
4511 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341

JARDINA, PHILIP M. 22 ACT I
711 CHURCH ST., DECATUR 30030

JOHNSON, EDWARD L. 22 ACT OR
2910 N. DRUID HILLS RO., ATLANTA 30329

JOHNSON, LEWIS O. 22 ACT I
4303 LAVISTA RD., TUCKER 30084

JOINER, JAMES C., III 22 ACT OPH
755 COLUMBIA CR., DECATUR 30030

JONES, ERNEST J. 22 ACT FP
2644 CANDLER PKWY., DECATUR 30030

JONES, FOREST O. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345

JONES, GEORGE P. 22 ACT
3596 CHAMBLEE TUCKER RO., CHAMBLEE 30341

JOVE, JULIO 22 ACT OR
3644 CHAMBLEE-TUCKER RD., CHAMBLEE 30341

KEENER, ELLIS B. 22 ACT NS
365 WINN WAY, DECATUR 30030

KEETON, WILLIAM F. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

KERLEY, CLIFFORD M. 22 ACT R
5247 FOREST SPRINGS DR., DUNWOODY 30338

KERR, WM. K. 22 ACT FP
P. O. BOX 80525, CHAMBLEE 30341

KINLAW, WM. K., JR. 22 ACT NS
365 WINN WAY, DECATUR 30030

KNIGHT, EVELYN A. 22 ACT PD
3750 DIAL DP., CLARKSTON 30021

LASSITER, NOLAN M. 22 ACT I
1275 MCCONNELL DR., DECATUR 30030

LEADER, EDWARD 22 ACT P
1970 CLIFF VALLEY RD., N.E., ATLANTA 30329

LEE, HOWARD B. 22 ACT FP
603 CHURCH ST., DECATUR 30030

LESLIE, JAMES T. 22 A PD
50 SEVENTH ST., N.E., RM 404, ATL. 30323

LEVENSON, DAVID S. 22 ACT OPH
2754 N. DECATUR RD., DECATUR 30030

LITTON, JAMES H. 22 ACT FP
4173 FIRST AVE., TUCKER 30084

LOBEL, A. BEATA 22 ACT PD
1275 MCCONNELL DR., DECATUR 30033

LONG, W. NEWTON 22 ACT OBG
80 BUTLER ST., S. E., ATLANTA 30303

LUCKETT, JAMES M. 22 ACT R
2701 N. DECATUR RD., DECATUR 30030

MACKEY, DAN M. 22 ACT D
4511 CHAMBLEE DUNWOODY RD., ATLANTA 30319

MAGEE, KENNETH G. 22 ACT PD
4536 CHAMBLEE DUNWDY RD., ATLANTA 30341

MANSFIELD, DONALD L. 22 ACT OBG
3576 CHAMBLEE TUCKER PD., CHAMBLEE 30341

MASON, JAMES L. 22 ACT P
1365 CLIFTON RD., N. E., ATLANTA 30322

MATHEWS, WAYNE S. 22 ACT PD
2100 PARK LAKE DR., N.E., ATLANTA 30345

MATTHEWS, LAWRENCE P. 22 DE5 OBG
1357 OXFORD RD., N. E., ATLANTA 30307

MATTHEWS, W. FRANK 22 ACT PATH
DEKALB GENERAL HDSP., DECATUR 30030

MATTISON, RICHARD C. 22 ACT PI
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

MCANULTY, MARTHA J. 22 ACT I
3390 PEACHTREE RD., N.E., ATLANTA 30326

MCCORMICK, GLENN E., JR. 22 ACT O
755 COLUMBIA CR., DECATUR 30030

MCCUISTON, C. F. 22 ACT I
3610 CHAMBLEE-TUCKER RD., CHAMBLEE 30341

MCCUROY, WILLIS T. 22 ACT FP
P. O. BOX 336, STONE MOUNTAIN 30083

MCODWELL, CHARLES W., JR. 22 ACT OPH
542 CHURCH ST., DECATUR 30030

MCGINNIS, LAMAR S., JR. 22 ACT SL
365 WINN WAY, DECATUR 30030

MCLANE, JOHN E. 22 ACT OBG
365 WINN WAY, DECATUR 30030

MEES, DONALD E., JR. 22 DE2 R
NO CURRENT ADDRESS

MENDENHALL, W. A. 22 DE5 FP
3830 CHAMBLEE-DUNWDY RD., CHAMBLEE 30341

METZGER, C. ROBERT, JR. 22 ACT PD
6 LAVISTA PERIMETER OFC. PK., TUCKER 30084

MICHAELS, JOHN 22 ACT PD
2100 PARK LAKE CR., N.E., ATLANTA 30329

MILSAP, JAMES H., JR. 22 ACT R
2910 N. DRUID HILLS RD., ATLANTA 30329

MINOR, B. DONALD 22 ACT R
2256 SAGAMORE HILLS DR., DECATUR 30033

MOON, ELLIOTT C. 22 ACT OBG
5 LAVISTA PERIMETER PARK, TUCKER 30084

MOORE, MEL T. 22 ACT
3646 MARKET ST., CLARKSTON 30021

MORGAN, DAVID L. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345

MORGAN, FRANK E., JR. 22 ACT R
755 COLUMBIA CR., DECATUR 30030

MORGAN, Z. V., JR. 22 ACT I
542 CHURCH ST., DECATUR 30030

MORSE, CHESTER W. 22 ACT I
711 CHURCH STREET, DECATUR 30030

MOSELEY, TEDDY C. 22 ACT OBG
365 WINN WAY, DECATUR 30030

MOUSSAKHANI, JOSEPH 22 ACT GBG
3041 ACCESS RD., N.E. EXP., CHAMBLEE 30341

NADAL, GUILLERMO 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

NAIB, Z. M. 22 ACT PATH
80 BUTLER ST., S.E., ATLANTA 30303

NICHOLS, DAVID M. 22 ACT P
2871 CRAVEY DR., ATLANTA 30345

NODAL, RONALDO R. 22 ACT OBG
7 LA VISTA PER. OFC. PK., TUCKER 30084

OKEL, BENJAMIN B. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033

OLKOWSKI, Z. L. 22 A R
WINSHIP CLINIC, EMORY UNIV., ATLANTA 30322

OQUIN, WILLIAM P. 22 ACT FP
2140 HENDERSON MILL RD., ATLANTA 30345

PARSONS, RICHARD C. 22 ACT ALR
755 COLUMBIA CR., DECATUR 30030

PELTZ, ROSEMONDE S. 22 ACT I
755 COLUMBIA DR., DECATUR 30030

PERKINS, JACK B. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

PIRKLE, QUENTIN 22 ACT SU
1313 DRESDEN DR., N. E., ATLANTA 30319

POWELL, F. C. 22 ACT I
3307 WILTSHIRE DR., AVONDALE ESTATES 30083

POWELL, RALPH W. 22 ACT SL
1365 CLIFTON RD., N. E., ATLANTA 30322

PRATER, R. BURT, JR. 22 ACT FP
4555 N. SHALLOWFORD RD., ATLANTA 30341

PRINCE, RUSSELL B. 22 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

PRINTZ, DON W. 22 ACT D
4303 LAVISTA RD., TUCKER 30084

PRUETT, JAMES E. 22 ACT ALR
755 COLUMBIA CR., DECATUR 30030

RAAEN, TOM O. 22 ACT PATH
DEKALB GENERAL HOSPITAL, DECATUR 30030

RANDALL, R. BEAUVAIS, JR. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30032

RAUBER, ALBERT PAUL 22 ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322

RAWLS, WILLIAM J. 22 ACT I
755 COLUMBIA CR., DECATUR 30030

RAY, WALKER L. 22 ACT PD
4112 E. PONCE DELEON AVE., CLARKSTON 30021

REICH, ROBERT A. 22 ACT I
755 COLUMBIA DR., DECATUR 30030

REMY, HENRY 22 ACT PD
798 RAYS RD., STONE MOUNTAIN 30083

RHAME, MARLAN L. VAN 22 ACT P
755 COLUMBIA CR., DECATUR 30030

RHENEY, THEODORE B. 22 ACT FP
2701 N. DECATUR RD., DECATUR 30030

RICE, M. HOBSON 22 ACT OPH
542 CHURCH STREET, DECATUR 30030

ROGERS, J. V., JR. 22 ACT R
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

ROSENBERG, RAYMOND 22 ACT PD
11 LAVISTA PERIMETER OFC. PK., DEC 30084

ROUNTREE, CLYDE B. 22 ACT P
755 COLUMBIA CR., DECATUR 30030

ROWELL, ROGER R. 22 ACT OPH
542 CHURCH ST., DECATUR 30030

ROWLAND, DAVID M. 22 ACT L
755 COLUMBIA CR., DECATUR 30030

SANDERS, FLOYD R. 22 ACT FP
603 CHURCH ST., DECATUR 30030

SAWYER, HORACE K., JR. 22 ACT FP
2054 LAWRENCEVILLE HWY., DECATUR 30033

SCHNEIDERMAN, STEVEN M. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033

SCHREEDER, JOHN M. 22 ACT FP
3652 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341

SEESE, PERRY G. 22 ACT P
2258 NORTHLAKE PKWY., TUCKER 30084

SESSIONS, GEORGE P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

SHAVIN, JOEL S. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084

SHOTTS, RON F. 22 ACT OTC
1989 N. WILLIAMSBURG DR., DEC. 30033

SILVER, WILLIAM E. 22 ACT OTO
1770 OLD SPRNGHSE LN, N.E., CHAMBLEE 30341

SIMMONS, JOHN W., III 22 ACT PD
4112 E.PONCE DE LEON AVE., CLARKSTON 30021

SIMMONS, M. FREEMAN 22 ACT FP
301 WOODVIEW DR., DECATUR 30030

SLADE, HELEN B. 22 ACT PD
768 JUNIPER ST., N. E., ATLANTA 30308

SMITH, DOUGLAS 22 ACT OR
1405 CHURCH ST., DECATUR 30030

SMITH, MIRIAM F. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033

SMITH, W. P. 22 DE5 I
P.O. BOX 552, AVONDALE ESTATES 30002

SMOOT, RICHARD H. 22 RET SU
P.O. BOX 174, DECATUR 30030

SOTUS, PETER C. 22 ACT SL
3606 CHAMBLEE-TUCKER RD., CHAMBLEE 30341

SPRUELL, WILLIAM H. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033

STATHAM, GEORGE W. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021

STATON, JEAN STEWART 22 ACT I
2754 N. DECATUR RD., DECATUR 30033

STEVES, ELMA M. 22 ACT PD
3624 CHAMBLEE TUCKER RD., CHAMBLEE 30341

STEVES, SEVERO 22 ACT OBG
204 PIKE ST., LAWRENCEVILLE 30245

STOVALL, RUSSELL H., JR. 22 ACT OTC
755 COLUMBIA CR., DECATUR 30030

STROM, CARL H. 22 ACT PM
3300 MEMORIAL DR., DECATUR 30032

STUBBS, O. WYTCH, JR. 22 ACT FP
3628 CHAMBLEE TUCKER RD., CHAMBLEE 30341

STUBBS, TRAWICK H. 22 ACT PH
47 TRINITY AVE., S.W.,ATLANTA 30334

STUCKEY, KATHERINE 22 ACT ANES
P.O. BOX 33247, DECATUR 30033

SYN, WAI YUN 22 ACT I
2100 PARKLAKE DR., N. E., ATLANTA 30345

TALBOTT, GEORGE D. 22 ACT I
500 WINN WAY, DECATUR 30030

TATUM, JOSEPH C. 22 ACT DR
755 COLUMBIA DR., DECATUR 30030

TAYLOR, JOHN EDWIN, JR. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021

TEATE, H. LUTEN, JR. 22 ACT PD
1901 CENTURY BLVD., N. E., ATLANTA 30345

TENEBAUM, STANLEY M. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084

TILLMAN, RALPH A. 22 ACT OBG
3290 MEMORIAL DR., DECATUR 30032

TINDALL, GEORGE T. 22 ACT N
1365 CLIFTON RD., ATLANTA 30322

TINDALL, SUZIE C. 22 ACT N
DECATUR N. PROF. BLDG., DECATUR 30030

TIPPINS, WM. C., JR. 22 ACT OBG
5040 SNAPFINGER WOODS DR., DECATUR 30030

TRENT, R. M. 22 ACT FP
2054 LAWRENCEVILLE HWY, DECATLR 30032

TROTTER, JOHN F. 22 ACT FP
2054 LAWRENCEVILLE HIWAY., DECATUR 30033

TUGGLE, M. VIRGINIA 22 ACT I
1336 COLUMBIA DR., DECATUR 30032

TURNER, DANIEL R. 22 ACT I
755 COLUMBIA CR., DECATUR 30030

TURNER, DON W. 22 ACT P
2905 PEACHTREE RD., N.E., ATLANTA 30305

UEHLING, EDWARD R. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033

VANDIVER, ROY W. 22 ACT N
365 WINN WAY, DECATUR 30030

VINSON, T. D. 22 ACT PH
440 WINN WAY, DECATUR 30030

VINTON, L. M., JR. 22 ACT FP
1043 LAKESHORE DR., AVONDALE ESTATES 30002

VOGLER, WM. R. 22 ACT I
2057 CLAIRMONT RD., DECATUR 30033

WADE, ROBERT C. 22 ACT
3371 COLUMBIA WOODS DR., DECATUR 30032

WALDEN, CHARLES W. 22 ACT P
1989 N. WILLIAMSBURG DR., DECATUR 30033

WALKER, JAMES A. 22 ACT L
755 COLUMBIA DR., DECATUR 30030

WALKER, JEROME M., JR. 22 ACT N
755 COLUMBIA CR., DECATUR 30030

WALKER, JOHN W. 22 ACT OBG
365 WINN WAY, DECATUR 30030

WALKER, KNOX, JR. 22 ACT OR
1405 CHURCH ST., DECATUR 30030

WALKER, MOFFETT R., JR. 22 ACT I
BOX 3210, ATLANTA 30302

WALKER, W. W., III 22 ACT OBG
365 WINN WAY, DECATUR 30030

WALLACE, RUSSELL W., JR. 22 ACT N
755 COLUMBIA DR., DECATUR 30030

WALZ, PETER O. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033

WARD, CHARLES J. 22 ACT OBG
365 WINN WAY, DECATUR 30030

WARD, WILLIAM T., JR. 22 ACT FP
231 E PONCE DE LEON AVE., 30030

WATKINS, CHARLES B. 22 ACT FP
3543 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

WATKINS, W. LORRAINE 22 ACT PO
69 BUTLER ST., S. E., ATLANTA 30303

WHITE, WM. P. 22 ACT PD
558 MEDLOCK RD., DECATUR 30030

WHITEHURST, JOHN O. 22 ACT SL
1365 CLIFTON RD., N.E., ATLANTA 30322

WHITSON, THEODORE C. 22 ACT PL
755 COLUMBIA DR., DECATUR 30030

WILKERSON, BERNIE J., JR. 22 ACT FP
2508 CARROLL AVE., CHAMBLEE 30341

WILLIAMS, JAMES O. 22 ACT PO
4511 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

WILLS, S. ANGIER 22 ACT SL
755 COLUMBIA DR., DECATUR 30030

WILSON, HENRY H. 22 ACT PD
1510 OAK GROVE RD., DECATUR 30033

WYATT, SPARKMAN H. 22 ACT P
2017 DESMOND DR., DECATUR 30033

WYLIE, JAMES E. 22 ACT OBG
365 WINN WAY, DECATUR 30030

ZWEIG, ARNOLD 22 ACT OTC
3644 CHAMBLEE TUCKER RD., ATLANTA 30341

23—DOUGHERTY (Baker, Lee)

ADAMS, WILLIE, JR. 23 ACT OBG
711 N. MONROE ST., ALBANY 31701

ARELLANO, BERNARO G. 23 ACT FP
507-3RD AVE., ALBANY 31701

ARMSTRONG, EDWARD S. 23 ACT I
223 THIRD AVE., ALBANY 31705

BATEMAN, J. DAN 23 ACT SL
410-12 FOURTH AVE., ALBANY 31705

BERG, JOSEPH L. 23 ACT OPH
P. O. BOX 483, ALBANY 31702

BLACKSHEAR, JOSEPH R. 23 ACT EM
P.O. BOX 1828, ALBANY 31702

BOLTON, RICHARD S. 23 ACT PH
1109 N. JACKSON ST., ALBANY 31705

BOWMAN, M. B. 23 ACT SL
1104 N. MONROE ST., ALBANY 31705

BOYD, DONALD L. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701

BOYETTE, DAVID M. 23 ACT OTO
804 FOURTEENTH AVE., ALBANY 31705

BRIDGER, CLARENCE E. 23 ACT PATH
P.O. BOX 1828, ALBANY 31702

BRIDGES, WILLIAM H. 23 ACT R
P. O. BOX 1828, ALBANY 31702

BUCKNER, LESLIE MARVIN 23 ACT G
ROUTE 2, BOX 446, LEESBURG, GA. 31763

BUCKNER, MICHAEL S. 23 ACT PATH
ROUTE ONE, HEADLAND, ALA. 36345

BUSH, LEON H. 23 ACT I
1009 N. MONROE, ALBANY 31701

CARTER, OTHA B., JR. 23 ACT SL
1009 N. MONROE ST., ALBANY 31701

CHASTAIN, GEORGE M. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702

COATES, GRAHAM 23 ACT P
1112 N. MADISON, ALBANY 31705

COLEMAN, WILLIAM MCL. 23 ACT OR
810 14TH AVE., ALBANY 31705

COLLINS, CHAPPELL A., JR. 23 ACT FP
806 14TH ST., ALBANY 31705

CRIMMINS, L.T. 23 ACT SL
1009 N. MONROE, ALBANY 31701

DICKINSON, RICHARD F. 23 ACT R
P.O. BOX 1924, ALBANY 31702

DUNN, ROBERT G., JR. 23 ACT R
P.O. BOX 1924, ALBANY 31702

EASON, HARMER O., JR. 23 ACT I
207 E. WILLINGHAM, SYLVESTER 31791

FINDLAY, PRENTISS E. 23 ACT PD
412 FOURTH AVE., ALBANY 31705

FINNEY, C. E. 23 ACT OPH
521 THIRD AVE., ALBANY 31701

FLOURNOY, EDWIN E., JR. 23 ACT FP
1009 N. MONROE, ALBANY 31701

FOUNTAIN, T. GRAY 23 ACT SL
910 N. JEFFERSON, ALBANY 31705

FOWLER, MARK W. 23 ACT FP
1010 N. MADISON ST., ALBANY 31701

FREEMAN, ATWOOD M., JR. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701

GEORGE, WILLIAM M., JR. 23 ACT FP
907 JEFFERSON ST., ALBANY 31707

GILLESPIE, CHARLES B. 23 ACT OR
810 14TH AVE., ALBANY 31701

GOLOSMITH, ABRAM O. 23 ACT OBG
P.O. BOX 714, ALBANY 31702

GORDON, WALTER C. 23 ACT SL
413 S. MADISON ST., ALBANY 31701

GRANT, JOHN R. 23 ACT OTO
804 14TH AVE., ALBANY 31705

GROVES, ROBERT H. 23 ACT FP
1100 N. MADISON ST., ALBANY 31701

GUILLEBEAU, F. OEMPSEY 23 ACT I
P. O. BOX 288, ALBANY 31702

HANCOCK, CARL V., JR. 23 ACT U
810-13TH AVE., ALBANY 31701

HARPER, WILLIAM FERRELL 23 ACT SL
810-13TH AVE., ALBANY 31701

HATTAWAY, JAMES R. 23 ACT U
810-13TH AVE., ALBANY 31701

HILSMAN, P. L. 23 ACT OBG
1599 MEMORIAL DR., S. E., ATLANTA 30317

HOLLIS, CHARLES O., JR. 23 ACT I
P. O. BOX 288, ALBANY 31702

HOLMAN, C. M. 23 ACT OBG
410 FOURTH AVE., ALBANY 31705

HOOD, HERB L. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702

HUBBARD, JAMES A. 23 ACT OBG
401 S. MADISON, ALBANY 31701

INMAN, J. S., JR. 23 ACT OBG
907 N. JEFFERSON ST., ALBANY 31705

ISELE, ANTHONY F. 23 ACT PATH
P. O. BOX 1908, ALBANY 31702

JOHNSON, THOMAS D. 23 ACT I
P. O. BOX 288, ALBANY 31702

KIM, TAE W. 23 ACT ER
2010 W. BROAD, ALBANY 31707

KNOWLES, VAN CISE 23 ACT SL
410 FOURTH AVE., ALBANY 31705

LAMB, CHARLES C. 23 ACT FP
910 N. JEFFERSON., ALBANY 31705

LANE, W. K. 23 ACT
806 14TH ST., ALBANY 31705

LOWERY, WILLIAM D., JR. 23 ACT NS
419 FOURTH AVE., ALBANY 31705

MARTIN, JAMES B. 23 ACT OBG
707 N. JEFFERSON STREET, ALBANY 31705

MATTHEW, ROBERT A. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702

MAYHER, WILLIAM E., III 23 ACT NS
419 FOURTH AVE., ALBANY 31705

MCCALL, CHARLES S., JR. 23 ACT I
412 1/2 FOURTH AVE., ALBANY 31705

MCDANIEL, J. Z. 23 ACT L
C & S BANK BLDG., ALBANY 31701

MCKEMIE, W. FRANK 23 ACT
108 N. MONROE ST., ALBANY 31701

MCKINNEY, RAY L. 23 ACT R
P.O. BOX 1924, ALBANY 31702

MCLENDON, PEMBERT L. 23 ACT CR
803 N. JEFFERSON ST., ALBANY 31701

MEIER, JOHN A. 23 ACT OR
803 N. JEFFERSON ST., ALBANY 31701

MERREN, DAVID D. 23 ACT U
802 N. JEFFERSON, ALBANY 31705

MORRIS, T. W. 23 ACT FP
2203 NOTTINGHAM WAY, APT. 1, ALBANY 31707

OGLESBY, JAMES W. 23 ACT TS
910 N. JEFFERSON ST., ALBANY 31705

PARKER, GREGG 23 ACT OBG
401-B MADISON AVE., ALBANY 31707

PASCHAL, J. DEAN 23 ACT PD
910 N. JEFFERSON ST., ALBANY 31705

PINE, ROBERT F. 23 ACT P
308 THIRD AVE., ALBANY 31705

RAWLS, OTIS GREY 23 ACT SL
910 N. JEFFERSON, ALBANY 31705

REDFEARN, J. A. 23 DE5 I
527 BROAD AVE., ALBANY 31701

RHYNE, WALTER P. 23 DE5 DALR
P. O. BOX 806, ALBANY 31702

RICHARDSON, R. C. 23 ACT OALR
400 4TH AVE., ALBANY 31705

ROBERSON, PHIL E. 23 ACT OBG
P. O. BOX 343, ALBANY 31702

SANTOS, TEODORO DE LOS 23 ACT PATH
P.O. BOX 1828, ALBANY 31702

SEYMOUR, GLENN E. 23 ACT SL
412 FOURTH AVE., ALBANY 31705

SHIPLEY, JACOB L., JR. 23 ACT FP
411 S. MADISON ST., ALBANY 31701

SIMS, FRED E. 23 ACT ANES
107 S. JEFFERSON ST., ALBANY 31702

SUTTON, JAMES MACK, JR. 23 ACT PD
412 FOURTH AVE., ALBANY 31705

SWEAT, MAXWELL J., JR. 23 ACT PO
1007-1ST AVE., ALBANY 31701

TALLEY, J. LECONTE, JR. 23 ACT OBG
901 N. MADISON ST., ALBANY 31705

THOMAS, FRANK E. 23 DE1 PD
12 SHERWOOD RD. NW FT. WALTON BCH,FL 32548

TRULOCK, ALBERT S., JR. 23 ACT SL
800 N. JEFFERSON ST., ALBANY 31701

TURNER, DAVID A. 23 ACT P
420 4TH ST., ALBANY 31705

VAN DEVENTER, PHILLIP 23 ACT ANES
P.O. BOX 1828, ALBANY 31702

WALLER, ROBERT D. 23 ACT R
P.O. BOX 1924, ALBANY 31702

WILLIAMS, THEODORE G. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701

WOLFE, DAVID M. 23 A PH
P. O. BOX 273, LEESBURG 31763

WOOD, CLAYTON E. 23 ACT O
1009 N. MONROE, ALBANY 31701

WOODARD, OTIS J., JR. 23 ACT P
420-4TH ST., ALBANY 31705

24—CAMDEN-CHARLTON

BARKER, GEORGE W., JR. 24 ACT FP
ST. MARYS CLINIC, ST. MARYS 31558

DRURY, CARL M. 24 ACT FP
304 OSBORNE ST., ST. MARYS 31558

JACKSON, JOSEPH M. 24 ACT FP
MCCOY-JACKSON HOSPITAL, FOLKSTON 31539

MCCOLLUM, R. ROY, JR. 24 ACT
BOX 356, KINGSLAND 31548

OLIVEIRA, EDUARDO 24 ACT SL
304 OSBORNE ST., ST. MARYS 31558

25—EMANUEL

BROWN, R. G. 25 DE1 FP
SWAINSBORO 30401

FROST, H. R. 25 ACT
SWAINSBORO 30401

GILLIKIN, WILLIAM V., P.C 25 ACT FP
TWIN CITY 30471

MEADOWS, CARTER LEE 25 ACT SU
P. O. BOX 879, SWAINSBORO 30401

MOYE, R. J. 25 ACT FP
SWAINSBORO 30401

SMITH, H. W. 25 ACT OB
SWAINSBORO 30401

26—FLINT (Crisp, Dooly, Turner)

ADAMS, JOHN B, JR. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015

BARR, ROBERT E. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015

BUSBEE, PERRY G. 26 ACT FP
CORDELE 31015

CHRISTMAS, JOSEPH T. 26 ACT FP
VIENNA 31092

COLEMAN, OTHA K. 26 ACT FP
CORDELE 31015

GARRETT, ROBERT C. 26 ACT FP
412 CHURCH ST., VIENNA 31C92

GOSS, CHRISTOPHER C. 26 ACT FP
ASHBURN 31714

GOSS, WOODROW 26 ACT FP
ASHBURN 31714

GOWER, ORIEN T., JR. 26 ACT FP
CORDELE 31015

GREER, CHARLES C. 26 ACT OPH
BOX 1145, CORDELE 31015

MCARTHUR, CHARLES E. 26 OE5 FP
CORDELE 31C15

REYNOLDS, JAMES WILEY 26 ACT FP
P.O. BOX 549, ASHBURN 31714

VASKO, TRUMAN L. 26 ACT SL
P.O. BOX 247, VIENNA 31092

VENABLE, ROBERT N. 26 ACT FP
403 15TH AVE., CORDELE 31015

WILLIAMS, P. L., JR. 26 ACT FP
CORDELE 31015

27—FLOYD-POLK-CHATTOOGA

AOAIR, M. C. 27 ACT FP
FLOYD CO. HOSP.,ROME 30161

ANDERSON, BENJAMIN S. JR. 27 ACT FP
P. O. BOX 508, CEDARTOWN 30125

ANDREWS, RUSSELL E. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161

ATHA, JOHN F. 27 ACT FP
HAGUE AVE., ROCKMART 30153

ATHA, WILLIAM J., JR. 27 DE2
RT. 5, RIVERMONT RD., ROME 30161

AVERY, ANTHONY P. 27 ACT OTC
25 BALE ST., ROME 30161

BATTLE, LEE H., JR. 27 ACT SL
321 W 7TH STREET, ROME 30163

BELL, SIDNEY A. 27 ACT OR
HARBIN CLINIC, ROME 30161

BLANCHARD, WILLIAM 27 ACT SL
CEDARTOWN 30125

BOSWORTH, E. L. 27 ACT I
HARBIN CLINIC, ROME 30161

BRANNON, EMMETT S. 27 ACT I
MCCALL HOSPITAL, ROME 30162

BRICE, BOYCE S. 27 ACT SU
THE HARBIN CLINIC, ROME 30161

BROCK, ROY CRAWFORD 27 ACT SU
14 PROFESSIONAL COURT, ROME 30161

CAMPBELL, RICHARD P. 27 ACT FP
CEDARTOWN 30125

CATES, ROBERT M. 27 ACT OBG
10 HOSPITAL CIRCLE, ROME 30161

CONNELL, H. R., JR. 27 ACT GALR
HARBIN CLINIC, ROME 30161

CONNOR, ROBERT T. 27 ACT FP
101 JOHN MADDOX DR., ROME 30161

CORPE, R. F. 27 ACT SU
BATTEY STATE HOSP., ROME 30161

CULBRETH, ERNEST W. 27 ACT FP
319 W. 6TH ST., ROME 30161

CUMMINGS, T. E. 27 ACT FP
121 E. MAPLE ST., ROCKMART 30153

DAHLSTROM, SIGURD E. 27 ACT OR
321 TURNER MCCALL BLVD., ROME 30161

DAVIDSON, GENE G. 27 ACT I
HARBIN CLINIC, ROME 30161

DAVIS, RALPH J. 27 ACT SL
P. O. BOX 2227, ROME 30161

DELLINGER, RAIDEN W. 27 ACT SL
321 W. 7TH ST., ROME 30163

DICKINSON, JOHN I. 27 ACT SU
310 W. SIXTH ST., ROME 30161

DIXON, HAMILTON S. 27 ACT ALR
15 JOHN MADDOX DR., ROME 30161

DOOLEY, WILLIAM D. 27 ACT R
P. O. BOX 2625, ROME 30161

EDGENS, JACK R. 27 ACT
RT. 5 HORSESHOE BEND, ROME 30161

ELLIOTT, C. B. 27 ACT SU
CEDARTOWN 30125

ESENER, ISMAIL 27 ACT OBG
NO CURRENT ADDRESS

FARRELL, ROBERT A. 27 ACT PATH
FLOYD COUNTY HOSP., ROME 30161

FLOWERS, THOMAS EDWARD 27 ACT OPH
103 JOHN MADDOX DR., ROME 30161

GAFFORD, A. V. 27 ACT OALR
HARBIN CLINIC, ROME 30161

GATES, EDWARD M. 27 ACT NS
HARBIN CLINIC, ROME 30161

GILBERT, PETER G. 27 ACT U
HARBIN CLINIC, ROME 30161

GILBERT, WARREN 27 ACT FP
HARBIN CLINIC, ROME 30161

GOLDIN, HAROLD W. 27 ACT FP
ROCKMART 30153

GOODWIN, H. A., JR. 27 ACT FP
SUMMERVILLE 30747

GRAY, ARTHUR R. 27 ACT SL
310 W. SIXTH ST., ROME 30161

HADDSY, ELAINE L. 27 ACT ANES
P. O. BOX 27, ROME 30161

HADDSY, LOUIS S., JR. 27 ACT ANES
FLOYD HOSPITAL, ROME 30161

HARBIN, BANNESTER L., JR. 27 ACT SU
HARBIN CLINIC, ROME 30161

HARBIN, LESTER 27 ACT SU
HARBIN CLINIC, ROME 30161

HARBIN, R. M., JR. 27 DE5 SU
19 HORSELEG CREEK RD., ROME 30161

HARBIN, THOMAS S. 27 ACT OPH
HARBIN CLINIC, ROME 30161

HARBIN, W. P., JR. 27 ACT I
HARBIN CLINIC, ROME 30161

HIERN, BARRIE C. 27 ACT ANES
122 SADDLE MOUNTAIN RD., ROME 30161

HINES, ROBERT C. 27 ACT FP
HARBIN CLINIC, ROME 30161

HORTMAN, H. C. 27 ACT OBG
10 HOSPITAL CIR., ROME 30161

HOWSE, RALPH M. 27 ACT U
1825 MARTHA BERRY HWY., ROME 30161

HYDEN, WM. U. 27 ACT
TRION 30753

JACKSON, THOMAS W. 27 ACT OBG
326 MC CALL BLVD., ROME 30161

JENKINS, JAMES H. 27 ACT OBG
16 PROFESSIONAL COURT, ROME 30161

JENKINS, O. W. 27 R FP
LINDALE 30147

KELLY, JAMES MARVIN 27 ACT OR
HARBIN CLINIC, ROME 30161

LEIGH, RICHARD W. 27 ACT OBG
16 PROFESSIONAL COURT, ROME 30161

LIPSIUS, L. H. 27 ACT P
HARBIN CLINIC, ROME 30161

LITTLE, G. H. 27 DE1 FP
TRION 30753

LLORENTE, TEODULO M. 27 ACT FP
13 JOHNS MADDOX DR., ROME 30161

LOVVORN, JOHN R. 27 ACT P
HARBIN CLINIC, ROME 30161

LUCAS, WILLIAM H. 27 ACT I
5 PROFESSIONAL CT., ROME 30163

MARTENS, LESTER J. 27 ACT I
321 W. 7TH ST., ROME 30161

MATHENY, JAMES T. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161

MCCALL, J. T., JR. 27 ACT SU
MCCALL CLINIC, ROME 30162

MCGEHEE, JOHN M. 27 DE1 SL
BOX 277, CEDARTOWN 30125

MCMILLIAN, JAMES R. 27 ACT PD
HARBIN CLINIC, ROME 30161

MEACHAM, JACK R. 27 ACT FP
P. O. BOX 160, SUMMERVILLE 30747

MOORE, C. W. C. 27 ACT I
304 E. 2ND. AVE., ROME 30161

MOORE, CLIFF, JR. 27 ACT SU
P.O. BOX 1108, ROME 30161

MOORE, W. L. 27 OE4
NO CURRENT ADDRESS

MORGAN, TOBBY S. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161

MOSS, T. H. 27 ACT OBG
409 S. BROAD STREET, ROME 30161

MOSS, THOMAS H., JR. 27 ACT FP
409 S. BROAD ST., ROME 30161

NORA, FELICIANO C. 27 ACT SL
FLOYD HOSP., ROME 30161

NORTON, R. F. 27 ACT OBG
10 HOSPITAL CIR., ROME 30161

PENDLEY, WALTER O. 27 ACT FP
1001 AVENUE C, ROME 30163

PERKINS, G. E., II 27 ACT PLL
HORSELEG ESTATES, ROME 30163

RICHARDS, CHARLES K. 27 ACT FP
FLOYD HOSP., ROME 30161

RIGAS, LAMBROS C. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161

RIGAS, LAMBROS C. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161

ROSS, GRACE R. 27 ACT FP
P. O. BOX 846, SEA ISLAND 31561

ROUTLEDGE, JAMES A. 27 ACT SU
310 W. SIXTH ST., ROME 30161

SANCHEZ, ELIO S. 27 ACT I
BATTEY STATE HOSP., ROME 30161

SAPP, CLARENCE J. 27 ACT SU
200 E. 3RD ST., ROME 30161

SCHMIDT, DON 27 ACT FP
P. O. BOX 368, CEDARTOWN 30125

SEAGO, RICHARD W. 27 ACT SU
405 ALABAMA AVE., BREMEN 30110

SELF, STANLEY J. 27 ACT D
302 W. 6TH ST., ROME 30161

SENNETT, CHARLIE O., JR. 27 ACT PATH
FLOYD HOSP., ROME 30161

SMITH, CHARLES M. 27 ACT FP
ROCKMART 30153

SMITH, GARY L. 27 ACT FP
TRION 30753

SMITH, JAMES F. 27 ACT I
7 PROFESSIONAL COURT, ROME 30161

SMITH, LUCIUS S. 27 ACT R
FLOYD HOSPITAL, ROME 30162

SMITH, STEPHEN D. 27 ACT PD
10 HORSELEG CREEK RD., ROME 30163

SMITH, STUART A. 27 ACT OTC
15 JOHN MADDOX DR., ROME 30161

SPANJER, RAYMOND F. 27 ACT FP
P.O. BOX 846, SEA ISLAND 31561

SPIVEY, HERMAN E. 27 ACT FP
COMMERCE ST., SUMMERVILLE 30747

STARR, HARLAN M. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161

STERGUS, INGRID 27 RET PATH
BATTEY STATE HOSP., ROME 30161

TATE, JOHN DREWRY 27 ACT FP
MCCALL CLINIC, ROME 30162

TODINO, JOEL D. 27 ACT I
HARBIN CLINIC, ROME 30161

WALDREP, JACK MARION 27 ACT U
101 JOHN MADDOX DR., ROME 30161

WATERS, RAYMOND D. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161

WEAVER, JERRY D. 27 ACT FP
502 N. MAIN ST., CEDARTOWN 30125

WILCOX, C. R. 27 ACT OBG
10 HOSPITAL CIRCLE, ROME 30161

WYATT, BARBARA 27 ACT I
3 PROFESSIONAL COURT, ROME 30161

WYATT, C. J., JR. 27 ACT I
5 PROFESSIONAL COURT, ROME 30161

YOUNG, R. A. 27 ACT I
HARBIN CLINIC, ROME 30161

28—FRANKLIN-HART

BROWN, STEWART D., JR. 28 ACT FP
200 FRANKLIN SPRINGS ST., ROYSTON 30662

CACCHIOLI, LOUIS G. 28 ACT FP
HARTWELL 30643

CRUMP, HOYT W. 28 ACT FP
1196 JEFFERSON AVE., EAST POINT 30344

DAVIS, BILLY J. 28 ACT FP
GIBSON ST., HARTWELL 30512

FORD, WILLIAM C. 28 ACT FP
BOX 5, LAVONIA 30553

HARRIS, WESLEY W. 28 ACT FP
ROYSTON 30662

NELSON, ALVAH J., III 28 DE2 R
14735 CINDYWOOD, HOUSTON, TEXAS 77024

REDFIELD, RONALD L. 28 ACT SL
GIBSON ST., HARTWELL 30643

RIDGWAY, ROBERT E. 28 ACT FP
ROYSTON 30662

SHEARDUSE, JOHN N. 28 ACT FP
LAVONIA 30553

WILLIAMS, JOHN W., JR. 28 ACT FP
LAVONIA 30553

29—MEDICAL ASSOCIATION OF ATLANTA

ABBOTT, OSLER A. 29 DE1 SL
3037 W. PINE VALLEY RD., NW, ATLANTA 30305

ABEND, MELVIN N. 29 ACT SL
6063 PEACHTREE PKWY., NORCROSS 30071

ABERNATHY, A. H., III 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

ABERNATHY, ERNEST W. 29 ACT SL
157 N. MAIN ST.,JONESBORO 30236

ADAIR, HAROLD E. 29 ACT L
490 PEACHTREE ST., N.E., ATLANTA 30308

ADAMS, CHARLES D. 29 ACT D
34 SEVENTH ST. N. E., ATLANTA 30308

ADAMS, CHARLES P. 29 ACT SL
478 PEACHTREE ST. N. E., ATLANTA 30308

ADAMS, ELISABETH K. 29 A I
1685 MASON MILL RD,NE, ATL. 30329

ADERHOLT, HEWLETT EDWIN 29 ACT ANES
20 LINDEN AVE., ATLANTA 30308

AGNOR, E. B. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

AGRIN, ALFRED 29 A P
3916 BEECHWOOD DR., N. W., ATLANTA 30327

AGUILAR, AGUSTIN 29 ACT ANES
5662 QUEENSBOROUGH DR. N.E., ATLANTA 30328

AHMANN, PETER A. 29 ACT PD
1365 CLIFTON RD., N.E., ATLANTA 30322

AHN, YOUNG W. 29 ACT OBG
69 BUTLER ST.,S.E., ATLANTA 30303

AJOY, ANA B. 29 ACT ANES
BOX 1260 GUAYAQUIL, ECUADOR,S. AMER.

AKIN, JOHN T., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

ALARCON, ALFREDO 29 ACT SL
490 PEACHTREE ST., N. E., ATLANTA 30308

ALDEN, HERBERT S. 29 DE5 D
1293 PEACHTREE ST. N.E., ATLANTA 30309

ALDERETE, JOSEPH F. 29 S P
771 MCDONOUGH BLVD., S.E. ATLANTA 30315

ALDERMAN, EARL L. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

ALEXANDER, HAROLD H. 29 ACT DR
6500 VERNON WOODS DR.,N.E., ATLANTA 30328

ALFRED, DEWITT C., JR. 29 ACT P
80 BUTLER ST., S.E., ATLANTA 30303

ALLAN, CHRISTOPHER J. 29 ACT PA
1000 JOHNSON-FERRY RD., ATLANTA 30342

ALLEN, JOHN EDWARD, JR. 29 ACT PD
1649 CLEVELAND AVE., EAST POINT 30344

ALLGOOD, PIERCE 29 ACT OR
35 COLLIER RD., N.W., ATLANTA 30309

ALLMAN, FRED L. 29 ACT OR
615 PEACHTREE ST., N.E., ATLANTA 30308

ALPERIN, HERBERT 29 ACT PD
5675 PTREE-DUNWOODY RD.,N.E.,ATLANTA 30342

AMBROSE, SAMUEL S., JR. 29 ACT L
1365 CLIFTON RD., N.E., ATLANTA 30322

AMERSON, J. RICHARD 29 ACT SL
EMORY UNIVERSITY CLINIC, ATLANTA 30322

AMMONS, JOHN C. 29 S N
1670 CLAIRMONT RD., N. E., ATLANTA 30329

ANDERS, PATRICK L. 29 ACT OBG
2726 FELTON DRIVE, EAST POINT 30344

ANDERS, REBEKAH Y. 29 ACT FP
2726-A FELTON DR., EAST POINT 30344

ANDERSON, GROVER L. 29 ACT NS
4326 HARRIS VALLEY RD., N.W., ATL 30342

ANDERSON, JOHN M. 29 ACT P
490 PEACHTREE ST., N. E., ATLANTA 30308

ANDERSON, SAMUEL A. 29 DE5 P
2300 N. VIENNA, RUSTON, LA. 71270

ANDERSON, THOMAS J., JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308

ANDERSON, WILLIAM B. 29 ACT P
1970 CLIFF VALLEY WAY, N.E. ATLANTA 30329

ANDRADE, J. ROBIN DE 29 ACT DR
1365 CLIFTON RD., N.E., ATLANTA 30322

ANTROBUS, LEROY C. 29 ACT PD
495 E. CROSSVILLE RD., ROSWELL 30075

APPEL, SIDNEY D. 29 ACT SL
490 PEACHTREE ST., N.E., ATLANTA 30308

APPLE, DAVID F. 29 ACT DR
1938 PEACHTREE RD., N. W., ATLANTA 30309

ARANGO, VIRGILIO A. 29 ACT PD
35 LINDEN AVE. NE., ATLANTA 30308

ARMSTRONG, CHARLES L. 29 ACT FP
5675 PTREE DUNWOODY N.E., ATLANTA 30342

ARMSTRONG, GEORGE F., JR. 29 ACT PD
47 PEACHTREE PARK DR., N.E., ATLANTA 30309

ARNOLD, HARRY O., JR. 29 ACT OPH
1293 PEACHTREE ST. N. E., ATLANTA 30309

ARRUE, LUIS R. 29 ACT PD
259 ARROWHEAD BLVD, JONESBORO 30236

ARTEAGA, OLIVER 29 DE5 OALR
384 PEACHTREE ST., N.E., ATLANTA 30308

ASELMEYER, ALFRED JOHN 29 S PH
BATTEY STATE HOSP., ROME 30161

ASHER, HAROLD 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

ASKREN, EDWARD L., JR 29 ACT OPH
1293 PEACHTREE ST. NE., ATLANTA 30309

ASKREN, EDWARD L., III 29 ACT P
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

ATKINSON, STEWART 29 ACT OPH
705 JUNIPER ST., N.E., ATLANTA 30308

ATWATER, JOHN S. 29 ACT GE
478 PEACHTREE ST. N.E., ATLANTA 30308

ATWATER, JOHN S., JR. 29 DE4 I
1920-26TH AVE. NW, ROCHESTER, MINN. 55901

AVEN, C. C. 29 DE5
ROUTE 2, MARIETTA 30060

AVERETT, JAMES E., JR. 29 ACT OR
35 COLLIER RD., N.W., ATLANTA 30309

AVERY, WILLIAM G. 29 ACT OBG
275 CARPENTER DR., N.E., ATLANTA 30328

AYER, G. DARRELL, JR. 29 ACT PATH
BOX 12466, ATLANTA 30305

AZAR, GORDON J. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BACKERMAN, IVAN A. 29 ACT OBG
1311 CLEVELAND AVENUE, EAST POINT 30344

BAILEY, JAMES A. 29 ACT PM
2797 CAMPBELLTON RD., S.W., ATLANTA 30311

BAILEY, M. THOMAS, JR. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BAIRD, JOSEPH B., JR. 29 ACT P
1970 CLIFF VALLEY WAY,N.E., ATLANTA 30329

BAIRD, L. STEPHENS 29 ACT SL
1835 DELOWE DR. S.W., ATLANTA 30311

BAKER, CHARLES R. F., JR. 29 A SL
69 BUTLER ST., S. E., ATLANTA 30303

BALBONA, JOSE L. 29 ACT P
3316 PIEDMONT RD., N. E., ATLANTA 30305

BALLARD, MARGUERITE C. 29 ACT I
3092 ARGONNE DR., N.W., ATLANTA 30305

BANCKER, EVERT A., JR. 29 DE1 I
125 RIVER NORTH DR., N.W., ATLANTA 30328

BANNISTER, JAMES P. 29 ACT P
478 PEACHTREE ST., N.E., ATLANTA 30308

BARKSDALE, C. R., JR. 29 ACT FP
44 SMITH ST., FAIRBURN 30213

BARNES, JOHN J. 29 ACT OBG
2045 PEACHTREE RD., NE, ATLANTA 30309

BARNES, JOSEPH H. 29 ACT OBG
401 PEACHTREE ST., N.E., ATLANTA 30303

BARNETT, CRAWFORD F., JR. 29 ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

BARNETT, JOHN E., JR. 29 ACT P
6363 ROSWELL RD., N.E., ATLANTA 30328

BARNETT, STEPHEN T., JR. 29 ACT OBG
490 PEACHTREE ST., N.E., ATLANTA 30308

BARROW, J. GORDON 29 ACT I
938 PEACHTREE ST., N.E., ATLANTA 30309

BARTHOLOMEW, PHILIP R. 29 ACT OBG
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

BASKIN, J. HAGIN, JR. 29 ACT SL
490 PEACHTREE ST. N. E., ATLANTA 30308

BATEMAN, NEEDHAM B. 29 ACT SL
401 PEACHTREE ST., N.E., ATLANTA 30308

BAYNE, LOUI G. 29 ACT DR
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BEACH, WILLIAM R., III 29 ACT PATH
731 W. PEACHTREE ST., N.E., ATLANTA 30308

BEARD, DONALD E. 29 DE1 L
400 LOG CABIN DR., SMYRNA 30080

BEASLEY, ERNEST W., JR. 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

BECERRA, HERNAN 29 ACT FP
2741 BAYARD ST., EAST PT. 30344

BELL, FRED M., JR. 29 ACT SU
478 PEACHTREE ST., N. E., ATLANTA 30308

BELL, HUGH V., JR. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344

BENNETT, W. FRED, JR. 29 ACT I
3250 HOWELL MILL RD., N.E., ATL 30327

BENNETT, WM. H. 29 OE3 L
829 W. WESLEY RD., N.W., ATL. 30327

BERGER, LOUIS 29 ACT OPH
950 W. PEACHTREE ST. N. W., ATLANTA 30309

BERGER, MERTON B. 29 ACT P
5600 ROSWELL RD., N.E., ATLANTA 30042

BERGHERM, BRUCE A. 29 ACT ANES
1968 PEACHTREE RD., N. W., ATLANTA 30309

BERMAN, JEROME O. 29 ACT PD
6500 VERNON WOODS RD., N.E., ATLANTA 30328

BERN, GERHARD O. 29 S I
275-5TH ST., NW, ATLANTA 30332

BERNSTEIN, JEFFREY A. 29 ACT OBG
3312 PIEDMONT RD., N.E., ATLANTA 30305

BERRY, C. MARKHAM 29 OE2 FP
4665 MYSTIC DR., N.E., ATLANTA 30342

BERRY, JOSEPH N. 29 ACT I
6500 VERNON WOODS DR., N. E., ATL. 30328

BICKERS, DONALD 29 ACT NS
3250 HOWELL MILL RD.,NE, ATLANTA 30327

BIENERT, HENRY J. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344

BIGGERS, WILLIAM H. 29 ACT P
1365 CLIFTON RD., N. E., ATLANTA 30322

BILSTEN, GEORGE G. B. 29 ACT N
35 COLLIER RD., N.W., ATLANTA 30309

BIRCH, HERBERT W. 29 ACT OBG
1365 CLIFTON RD., N. E., ATLANTA 30322

BISHOP, LINTON H., JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308

BIVENS, EDWARD S. 29 ACT R
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BIVINGS, F. LEE 29 OE5 PD
3110 HABERSHAM RD., NW, ATLANTA 30305

BLACK, CLYDE E. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344

BLAINE, B. C. 29 ACT I
2034 MAIN STREET, N. W., ATLANTA 30318

BLALOCK, JOHN C. 29 OE5 SU
734 W. WESLEY RD., N. W., ATLANTA 30327

BLALOCK, TULLY T. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

BLALOCK, TULLY T., JR. 29 OE2 I
EMORY UNIV. HOSP., ATLANTA 30322

BLANO, JAMES W., JR. 29 ACT ANES
1364 CLIFTON RD., N.E., ATLANTA 30322

BLANK, SAMUEL 29 S
1670 CLAIRMONT RD, NE, DECATUR 30033

BLASINGAME, JOHN T., JR. 29 ACT SU
75 PIEDMONT AVE., N. E. ATLANTA 30303

BLEICH, ALLAN C. 29 ACT I
5675 PTREE-ONWOY RD.,N.E., ATL. 30342

BLEICH, J. K. 29 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

BLOCK, DONALD L. 29 ACT OBG
100 COLONY SQ., SUITE 1601, ATLANTA 30309

BLUMBERG, MAX M. 29 ACT I
33 PONCE DE LEON AVE., N.E., ATLANTA 30308

BLUMBERG, RICHARD W. 29 ACT PD
69 BUTLER ST. S. E., ATLANTA 30303

BLUMENTHAL, IRVIN 29 ACT SU
384 PEACHTREE ST. N. E., ATLANTA 30308

BOATWRIGHT, MARTHA H. 29 ACT P
1970 CLIFF VALLEY WAY NE., ATLANTA 30329

BOGER, RICHARD E. 29 ACT PD
5675 PTREE-ONWOY RD., STE. 502, AT 30342

BONCURANT, WILLIAM 29 ACT OR
478 PEACHTREE ST., NE, ATLANTA 30308

BONNER, JOHN T. 29 ACT ANES
69 BUTLER ST., S. E., ATLANTA 30303

BOOTH, ARTHUR S. 29 ACT SU
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BORDERS, JUEL PATE 29 ACT OBG
375 AUBURN AVE., S.E., ATL. 30312

BORDON, JOSE ANTONIO 29 ACT ANES
159 FOREST AVE., N. E., ATLANTA 30303

BOSTWICK, JOHN, III 29 ACT PL
25 PRESCOTT ST., NE, ATLANTA 30308

BOSWELL, JOHN R. 29 ACT ANES
6237 BLACKWATER TRAIL N.W., ATLANTA 30328

BOTTOMY, JOHN R. 29 ACT OBG
2794 WOODLAKE PARK DR., N. E., ATL. 30329

BOWEN, EDWARD G. 29 ACT CBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BOWEN, ROBERT W. 29 ACT OBG
217 ARROWHEAD BLVD., JONESBORO 30236

BOYETT, JAMES E. 29 ACT TS
P. O. BOX 429, EAST POINT 30344

BRACKETT, J. GORDON 29 ACT ALR
340 BOULEVARD, N.E., ATLANTA 30312

BRACKETT, MORRIS E. 29 A
47 TRINITY AVENUE, S.W., ATLANTA 30334

BRANNON, LAWRENCE T. 29 ACT P
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BRANTLEY, MARVIN A. 29 ACT P
1365 CLIFTON RD., N.E., ATLANTA 30322

BRANTLY, EDMUND B. 29 ACT R
20 LINDEN AVE., N.E., ATLANTA 30308

BRASWELL, L. RENDER 29 R FP
143 W. PACE FERRY RD., N.W., ATLANTA 30305

BRAWNER, JAMES N., III 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

BREGMAN, LARRY 29 ACT PD
4536 CHAMBLEE-DUNWOODY RD., ATLANTA 30341

BREWER, JOHN M., JR. 29 ACT O
384 PEACHTREE STREET, N.E. ATLANTA 30308

BREWER, SPENCER S., JR. 29 ACT I
1938 PEACHTREE RD., NW, ATLANTA 30309

BRINSFIELD, DOROTHY 29 ACT PD
2236 SPRING CREEK RD., DECATUR 30033

BROOKS, W. SCOTT, JR. 29 ACT I
1365 CLIFTON RD, NE, ATLANTA 30322

BROOME, HARRY L. 29 ACT OR
960 JOHNSON FERRY RD., N.E., ATLANTA 30328

BROWN, ALGIE C. 29 ACT P
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BROWN, BOBBY C. 29 ACT PATH
1364 CLIFTON RD., N.E., ATLANTA 30322

BROWN, CHARLES E. 29 ACT I
21 EIGHTH ST. N. E., ATLANTA 30309

BROWN, CHARLES W. 29 ACT OR
478 PEACHTREE ST., N.E., ATLANTA 30308

BROWN, COLEMAN M. 29 ACT P
1938 PTREE RD. NW., ATLANTA 30309

BROWN, H. EUGENE 29 OE1 I
622 PARK LN., DECATUR 30033

BROWN, HOWARD S. 29 ACT TS
6500 VERNON WOODS DR., N.E., ATL. 30328

BROWN, JIMMY S. 29 ACT PD
3162 PIEDMONT RD., N.E., ATLANTA 30305

BROWN, LESTER A. 29 ACT ALR
490 PEACHTREE ST. N. E., ATLANTA 30308

BROWN, NELSON H. 29 ACT I
478 PEACHTREE ST., N. E., ATLANTA 30308

BROWN, ROBERT H. 29 ACT ALR
3280 HOWELL MILL RD., N.W., ATLANTA 30327

BROWN, ROBERT L. 29 ACT SU
R. WINSHIP CL, EMORY HOSP., ATLANTA 30322

BROWN, S. ROSS 29 OE1 ANES
NO CURRENT ADDRESS

BRUNER, BARBARA 29 A PD
69 BUTLER ST., S. E., ATLANTA 30303

BRUNT, GWYNNE T., JR. 29 ACT R
3312 PIEDMONT RD., N.E., ATLANTA 30305

BRYANT, MILTON F., JR. 29 ACT SU
35 COLLIER RD., N.W., ATLANTA 30309

BUNNEN, ROBERT L. 29 A SU
3312 PIEDMONT RD., NE ATLANTA 30305

BURGE, DAN 29 ACT I
315 BOULEVARD N.E., ATLANTA 30312

BURNS, WILLIAM B., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

BURSON, E. NAPIER, JR. 29 ACT I
340 BOULEVARD, N.E., ATLANTA 30312

BURTON, HERBERT W. 29 ACT I
384 PEACHTREE ST., N. E., ATLANTA 30308

BUSEY, THOMAS J., JR. 29 ACT L
2748-B FELTON DR., EAST POINT 30344

BUSH, CHARLES K. 29 ACT P
47 TRINITY AVE., S.W., ATLANTA 30334

BUSH, O. B. 29 DE5 FP
57 RUMSON WAY, N.E., ATLANTA 30305

BUTLER, CHARLES W., JR. 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

BUTLER, RICHARD H. 29 S
P. O. BOX 20636, ATLANTA 30320

BUTLER, WALTER H. 29 ACT ANES
1110 VERNON SPGS. CT., N.W., ATLANTA 30327

BYRAM, JAMES F. 29 OE5 OBG
3080 RIDGEWOOD RD., N. W., ATLANTA 30327

BYRD, M. DANIEL 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

BYRNES, WILLIAM F. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344

CABRERA-MENDEZ, FABIO 29 OE2 P
80 BUTLER ST., S.E., ATLANTA 30303

CALHOUN, F. P., JR. 29 ACT OPH
1365 CLIFTON RD., N. E., ATLANTA 30322

CALLAWAY, GEORGE M., JR. 29 S I
1670 CLAIRMONT RD., N. E., ATLANTA 30329

CAMPBELL, WALLACE G. 29 ACT PATH
EMORY UN. SCH. OF MEDICINE, ATLANTA 30322

CAPLAN, DANIEL B. 29 ACT PD
69 BUTLER ST., S. E., ATLANTA 30303

CAPLAN, J. LOUIS 29 RET OTC
NO CURRENT ADDRESS

CARLINER, NATHAN H. 29 ACT I
1285 PEACHTREE ST., N.E., ATLANTA 30305

CARLISLE, O. B. 29 ACT OPH
3158 MAPLE DR., N. E., ATLANTA 30305

CARLOCK, KELLER S. 29 ACT PD
3162 PIEDMONT RD., N. E., ATLANTA 30305

CARPENTER, JAMES L. 29 OE1 P
6500 VERNON WOODS DR., N.E., ATL. 30328

CARR, RICHARD O. 29 S PM
3744 PREAKNESS DR., DECATUR 30034

CARRINGTON, LOUIE H. 29 ACT PD
275 CARPENTER DR., N. W., ATLANTA 30328

CARSON, JAMES MAXWELL 29 ACT
340 BOULEVARD, N. E., ATLANTA 30312

CARTER, A. W., JR. 29 ACT FP
4932 PHILLIPS DR., FOREST PARK 30050

CARTER, JAMES A. 29 ACT OTC
35 COLLIER RD., N.W., ATLANTA 30309

CARTER, SANDY B. 29 ACT I
1938 PTREE RD., NW, STE. 1502, AT 30327

CASEY, JESSE F. 29 A P
1929 N. RIDGEWAY RD., N.E., ATLANTA 30329

CASON, WILLIAM M. 29 OE5 OALR
6566 GLENRIDGE DR. N.E., ATLANTA 30328

CASTLE, ROBERT F. 29 ACT PD
272 BOULEVARD, N.E., ATLANTA 30308

CATANZARO, MARSHALL J. 29 ACT R
3312 PIEDMONT RD., N. E., ATLANTA 30305

CATHCART, DON F. 29 OE5 PD
490 PEACHTREE ST. N.E., ATLANTA 30308

CAUDILL, DARRELL R. 29 ACT TS
272 BOULEVARD, N.E., ATLANTA 30312

CHAIT, DONALD C. 29 ACT I
490 PEACHTREE ST. N.E., ATLANTA 30308

CHALMERS, RIVES 29 ACT P
2905 PEACHTREE RD. N. E., ATLANTA 30305

CHAMBERS, BENJAMIN M. 29 ACT OPH
490 PEACHTREE ST., N.E., ATLANTA 30308

CHANDLER, NEAL W. 29 ACT R
3312 PIEDMONT RO., N. E., ATLANTA 30305

CHAPPELL, AMEY 29 DE5 I
3750 PEACHTREE ST., N.E., ATLANTA 30319

CHELTON, ALICE G. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

CHELTON, L. GUY 29 ACT I
1999 CLIFF VALLEY WAY, N.E., ATLANTA 30329

CHEVES, H. L. 29 ACT FP
2726-B FELTON DR., EAST POINT 30344

CHORCHES, MICHAEL A. 29 ACT C
265 IVY ST., N.E., ATLANTA 30303

CHRISTY, JAMES H. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

CHYATTE, SAMUEL B. 29 ACT PM
EMORY UNIV. HOSP., ATLANTA 30322

CIBELLI, LOUIS A. 29 S RET
257 COLONIAL HOMES DR.,N.W., ATLANTA 30309

CLAIBORNE, T. STERLING 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

CLAIR, ALVIN F. 29 ACT D
4720 OLD VILLAGE LN., N.E., ATLANTA 30341

CLARK, JAMES E. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

CLARK, NEWTON T., JR. 29 ACT OR
275 CARPENTER DR., N.E., ATLANTA 30328

CLEMENTS, J.L., JR. 29 ACT I
4055 RANDALL MILL RD., N.W., ATL. 30327

CLEMENTS, STEPHEN D. 29 ACT I
1365 CLIFTON RD., N.E., ATLANTA 30322

CLIFTON, BEN F. 29 DE5 SU
4130 N. BROADLAND RD., N.W., ATLANTA 30305

CLINE, PETER J. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

CLINE, STEVEN G. 29 ACT G
1170 CLEVELAND AVENUE, EAST POINT 30344

CLINKSCALES, GRADY S. JR. 29 ACT OR
478 PEACHTREE ST., N.E., ATLANTA 30308

COBB, CLAUD P., JR. 29 ACT FP
REG. HOSP., N.W., GA., ROME 30161

COBBS, BEVERLY W., JR. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

COBERLY, JAMES CHAPMAN 29 S I
1670 CLAIRMONT RD., N. E., ATLANTA 30329

COFER, OLIN S. 29 DE5 G
735 PIEDMONT AVE. N. E., ATLANTA 30308

COHEN, DAVID M. 29 ACT OTO
6500 VERNON WOODS DR., N.E., ATLANTA 30328

COHEN, I. R. 29 ACT PD
950 W. PEACHTREE ST. N. E., ATLANTA 30309

COHEN, LAWRENCE 29 ACT OBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

COHEN, MARSHALL 29 ACT D
490 PEACHTREE ST., N.E., ATLANTA 30308

COHEN, PAUL G. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

COHEN, ROBERT A. 29 ACT I
2250 WINDY HILL RD., MARIETTA 30062

COHEN, SHELDON B. 29 ACT P
401 PEACHTREE ST. N. E., ATLANTA 30308

COLEMAN, REESE C., JR. 29 ACT U
401 PEACHTREE ST. N. E., ATLANTA 30308

COLES, CLEO P., JR. 29 ACT SL
2945 STONE HOGAN RD., CONN. ATLANTA 30331

COLES, W. C. 29 ACT R
3707 PEACHTREE RD., N.E., ATLANTA 30319

COLLIER, HOWARD J. 29 ACT C
6287 FAIRBURN RD., DOUGLASVILLE 30134

COLLIER, HAL F. 29 ACT R
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

COLLINS, WILLIAM C. 29 ACT OR
275 CARPENTER DR., N. E., ATLANTA 30328

CONRAD, CONSTANCE C. 29 A FP
1069 BURTON DR., N.E., ATL 30329

COOK, ARTHUR J. 29 ACT R
478 PEACHTREE ST., N. E., ATLANTA 30308

COOK, DANA F. 29 ACT ANES
1000 JOHNSON FERRY RD., N. E., ATL. 30305

COOK, ROGER P. 29 ACT OTO
104 UTICA SQ. MED. CTR., TULSA, OK 74114

COOK, WM. C., JR. 29 ACT ANES
3113 FARMINGTON DR., N.E., ATLANTA 30339

COOLEDGE, JOHN W. 29 ACT PD
4770 N. PEACHTREE RD., CHAMBLEE 30341

COOLEY, SARAH F. 29 A
3686 CREEKVIEW CIR., STONE MOUNTAIN 30083

COONEY, JAMES P. 29 R
3653 N. STRATFORD RD., N.E., ATLANTA 30305

COOPER, CHARLES F., JR. 29 RET OPH
1851 COLLAND DR., N. W., ATLANTA 30318

COOPER, FLOYD R., JR. 29 ACT NS
2718 FELTON DR., EAST POINT 30344

COOPER, GERALD R. 29 S I
CDC CENTER, ATLANTA 30333

COOPER, HARRY A. 29 ACT I
3393 PTREE RD., N.E., ATLANTA 30326

COOPER, LAWRENCE E. 29 ACT HE
2540 WINDY HILL RD., MARIETTA 30060

COOPER, R. DALE, JR. 29 ACT R
1474 HANOVER W. DR., N. W., ATLANTA 30327

COPPEDGE, W. W. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344

CORDER, V. WOODARD 29 ACT ANES
2367 HENDERSON MILL CT., ATLANTA 30345

CORLEY, C. C. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

CORTES, JULIO P. 29 ACT ANES
384 PEACHTREE ST., N. E., ATLANTA 30308

COUSINS, WILLIAM L. 29 DE5 I
1665 COOLEDGE RD., TUCKER 30084

COWAN, Z. S. 29 DE3 FP
1179 CLIFTON ROAD, N. E., ATLANTA 30316

COWART, G. THOMAS 29 ACT L
384 PEACHTREE ST. N. E., ATLANTA 30308

COX, ROSS J. 29 ACT FP
6363 ROSWELL RD., N.E., ATLANTA 30328

CRAVER, JOE M. 29 ACT IS
25 PRESCOTT ST., N.E., ATLANTA 30308

CRAWFORD, CLYDE L. 29 ACT SU
652 W. PEACHTREE ST. N. W., ATLANTA 30308

CRIDER, HARRY J., JR. 29 ACT OBG
1135 SHERIDAN RD., N. E., ATLANTA 30324

CRISP, NELIDA S. 29 S SU
3233 BUFORD HWY., N.E., ATLANTA 30329

CROFT, THOMAS J. 29 ACT NS
2718 FELTON DR., EAST POINT 30344

CRONCE, PAUL C. 29 ACT D
1293 PEACHTREE ST., N. E., ATLANTA 30309

CROSS, JAMES LEE 29 ACT OBG
340 BOULEVARD, N.E., ATLANTA 30312

CROW, ROBERT W. 29 ACT PL
1938 PEACHTREE RD., N.W., ATLANTA 30309

CRUISE, JOE S. 29 ACT PLL
384 PEACHTREE ST. N. E., ATLANTA 30308

CRUMBLEY, A. J., JR. 29 ACT SL
2788 BAYARD ST., EAST POINT 30344

CRUTCHER, JAMES CARROLL 29 S
1670 CLAIRMONT RD., N.E., DECATUR 30033

CUETO, JOSE R. DEL 29 ACT FP
2739 FELTON DR., EAST POINT 30344

CUMMINGS, ROBERT J., JR. 29 A OR
300 BOULEVARD, N.E., ATLANTA 30312

CUNNINGHAM, ROBERT P. 29 ACT I
SOUTHERN BEL. TEL.&TEL.,BOX 2211,ATL 30301

CURTIS, EARNEST M., JR. 29 ACT OBG
275 CARPENTER DR., SANDY SPRINGS 30328

CURTIS, WALKER L. 29 DE1 I
P. O. BOX 87100, COLLEGE PARK 30337

DALRYMPLE, DAVID E. 29 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

DANIEL, WM. W. 29 ACT OBG
5675 PTREE-DUNWOODY RD., N.E. ATL 30342

DANIELS, CHARLES W. 29 DE5 OBG
1647 N. ROCK SPRINGS RD., ATLANTA 30324

DAVENPORT, T. F. 29 DE5 PD
478 PEACHTREE ST., NE, ATLANTA 30308

DAVIDSON, EUGENE D. 29 ACT SU
1365 CLIFTON RD.,N.E.,ATLANTA 30322

DAVIDSON, JOHN K., III 29 ACT I
69 BUTLER ST., S.E., ATLANTA 30303

DAVIES, NICHOLAS E. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

DAVIS, ALBERT M. 29 ACT I
75 PIEDMONT AVE., N.E., ATLANTA 30303

DAVIS, DAVE M. 29 ACT P
1999 CLIFF VALLEY WAY, N.E., ATLANTA 30329

DAVIS, FLOYD L. O. 29 ACT OPH
2722-A FELTON DR., EAST POINT 30344

DAVIS, JAKE E. 29 ACT ANES
69 BUTLER ST., N.E., ATLANTA 30303

DAVIS, JOHN L., III 29 ACT OPH
3200 HOWELL MILL RD.,N.W., ATL. 30327

DAVIS, JOSEPH R. 29 ACT FP
6701 ROSWELL RD., N. E., ATLANTA 30328

DAVIS, M. BEDFORD, JR. 29 ACT SU
340 BOULEVARD N.E., ATLANTA 30312

DAVIS, MARVIN L. 29 ACT PD
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

DAVIS, R. CARTER, JR. 29 ACT I
1201 PTREE ST., N.E., ATLANTA 30361

DAVIS, ROBERT S. 29 ACT OBG
2100 PARKLAKE DR., N. E., ATLANTA 30345

DAVIS, SHELLEY C., JR. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

DAVIS,THOMAS A. 29 ACT P
1999 CLIFF VALLEY WAY, ATL. 30329

DAVIS, WILLIAM A., III 29 ACT R
35 LINDEN AVE., N. E., ATLANTA 30308

DAVIS, WILLIAM B. 29 R PD
2065 WALKER AVE., COLLEGE PARK 30337

DAVIS, WILLIAM S. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

DAVISON, ALEXIS H. 29 ACT I
478 PEACHTREE ST., N. E., ATLANTA 30308

DAWSON, JACK E., JR. 29 DE4 I
2225 RIADA DR., N.W., ATLANTA 30305

DE ARMAS, F. M. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344

DEAS, RALPH H. 29 DE1 OPH
3166 MAPLE DR., ATLANTA 30205

DEES, HOYT C. 29 ACT OBG
401 PEACHTREE ST., N. E., ATLANTA 30308

DEITCH, MILTON J. 29 ACT U
490 PEACHTREE STREET, N.E., ATLANTA 30308

DE LA PERRIERE, ARMAND 29 ACT OBG
3626 CHAMBLEE TUCKER RD, CHAMBLEE 30341

DELASHMUTT, ROBERT E. 29 ACT PATH
340 BOULEVARD, N.E., ATLANTA 30312

DEMBY, CHARLES E. 29 ACT SU
6646 CHURCH ST., DOUGLASVILLE 30134

DENIS, BRUNO 29 ACT FP
427 KING ARNOLD DR., HAPEVILLE 30354

DENMARK, L. D. 29 DE5 PD
5605 GLENRIDGE DR. N. E., ATLANTA 30305

DENNIS, BROWN W. 29 ACT I
1938 PEACHTREE ST., N. W., ATLANTA 30309

DENNISON, DAVID B. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

DENSLER, JAMES F. 29 ACT SU
319 W. LAKE AVE., ATLANTA 30318

DEW, J. HARRIS 29 ACT SL
3250 HOWELL MILL RD., N.W., ATLANTA 30327

DEW, J. HARRIS, JR. 29 ACT OPH
315B MAPLE DR., N. E., ATLANTA 30305

DIMON, JOS. H. III 29 ACT OR
1938 PEACHTREE RD., N.W., ATLANTA 30309

DINNERSTEIN, ALLAN J. 29 ACT OBG
259 ARROWHEAD BLVD., JONESBORO 30236

DOBES, WILLIAM L., JR. 29 ACT D
47B PEACHTREE ST., N.E., ATLANTA 30308

DODD, JOHN S., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

DOMINY, DALE E. 29 S SU
398B ASHENTREE DR., ATLANTA 30341

DORNEY, EDWARD R. 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322

DOWDA, F. W. 29 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

DOWLING, GEORGE BRACKETT 29 DE5 I
1 WEST COURT SQ., STE. 300, DECATUR 30035

DOWMAN, CHARLES E. 29 ACT NS
47B PEACHTREE ST. N.E., ATLANTA 30308

DOWMAN, CORDELIA K. 29 A PD
2550 BROOKDALE DR., NW, ATLANTA 30305

DUBOIS, RICHARD E. 29 ACT I
478 PEACHTREE ST., N.E., ATLANTA 30308

DULOCK, MALCOLM P. 29 ACT FP
1000 S. BUFORD HWY., NORCROSS 30071

DUNBAR, ERNEST A., JR. 29 ACT PD
1035 MAIN ST., FOREST PARK 30050

DUNBAR, RONALD W. 29 ACT ANES
1364 CLIFTON RD., N.E., ATLANTA 30322

DUNBAR, WALTER S. 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308

DUNLAP, ERNEST B., JR. 29 DE1 OR
9D0 ARTWOOD RD., N.E., ATLANTA 30307

DUNSTAN, EDGAR M. 29 DE5 I
71D PINETREE DR., DECATUR 30030

DURALDE, FERNANDO U. 29 ACT SL
2760 FELTON DR., EAST POINT 30344

DURRETT, DONALD M. 29 ACT R
1170 CLEVELANC AVE., EAST POINT 30344

DYCKMAN, EDWARD 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322

EARNEST, DAVID L., LT. 29 OE4 I
7500 E. CARSON ST., LONG BH., CALIF. 90801

EATON, S. BOYD 29 ACT R
265 IVY ST.,N.E.,ATLANTA 30303

EBERHART, CHARLES 29 DE1 U
173B COUNCIL BLUFF DR., ATLANTA 30345

ECHEMENDIA, MARIANO M. 29 ACT OBG
384 PEACHTREE ST., N.E., ATLANTA 30308

EDENFIELD, WILSON T. 29 ACT R
300 BOULEVARD, N.E. ATLANTA 30312

EDMONDSON, STEPHEN W. 29 ACT P
5D64 NANDINA LN., DUNWOODY 30338

EDWARDS, CHARLES H. 29 ACT P
1000 JOHNSON FRY RD., N. E., ATLANTA 30305

EDWARDS, WM. T., JR. 29 ACT OPH
121B W. PACES FRY RD., STE. 104, ATL 30327

EGAN, ROBERT L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322

EHIK, JULIUS 29 ACT P
811 JUNIPER ST., N.E., ATLANTA 30308

ELLIOTT, RALPH A. 29 A I
STUD HEALTH SERV., GA. TECH, ATLANTA 30308

ELLIS, JOHN O. 29 ACT R
384 PEACHTREE ST., N.E., ATLANTA 30308

ELMER, R. A. 29 ACT R
6500 VERNON WOODS DR., N.E., ATLANTA 30328

ELSAS, LOUIS J. 29 A PD
EMORY UNIV. SCHOOL OF MED., ATLANTA 30322

ELSEA, WILLIAM R. 29 ACT PH
99 BUTLER ST., SE, ATLANTA 30303

ELSON, EILEEN F. 29 OE1 PATH
7B SHERIDAN DR., N.E. 10, ATLANTA 30305

ELSON, SHIA H. 29 ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30345

ENGELHARDT, SAMUEL M., III 29 ACT OBG
710 PEACHTREE ST., N.E., ATLANTA 30309

EPSTEIN, JACOB 29 ACT OBG
1175 PEACHTREE STREET, NE, ATLANTA 30309

ERICKSON, PAUL T. 29 A PH
109 PARKWOOD LANE, ATL. 30030

ERKAN, NIZAMI V. 29 ACT PD
2730 FELTON DR., EAST POINT 30344

ESPINOZA, FRANCISCO T. 29 ACT SL
3065 AUSTELL RD., MARIETTA 30060

ESTES, RICHARD C. 29 ACT L
35 COLLIER RD., N.W., ATLANTA 30309

EUBANKS, OMER L. 29 ACT I
1143 ALPHARETTA ST., ROSWELL 30075

EUBANKS, WM. L. 29 ACT OPH
490 PEACHTREE ST., N.E., ATLANTA 30308

EVANS, ALBERT L. 29 ACT SL
735 PIEDMONT AVE. N. E., ATLANTA 30308

EVANS, E. C. 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

EVANS, JAMES A. 29 ACT ANES
384 PEACHTREE ST., N.E., ATLANTA 30308

EVANS, WM. W. 29 DE1 I
450 ROCK SPRINGS RD., N.E., ATLANTA 30324

EVERHART, GUY D. 29 ACT FP
1545 LA VISTA RD., N.E., ATLANTA 30329

EYZAGUIRRE, WM. A. 29 ACT C
5064 NANDINA LANE, DUNWOODY 30338

FANCHER, JAMES K. 29 DE5 I
31 MUSCOGEE AVE., N.E., APT. 6, ATL. 30305

FARUQUI, A. M. A. 29 A C
549 P@TREE ST., APT 703, ATLANTA 30308

FEIGENBAUM, ERNEST 29 A PH
U.S.A.I.D., BOX J, BALBOA CANAL ZONE 00101

FELDER, LOUIS H. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

FELDER, RICHARD E. 29 ACT P
6363 ROSWELL RD., N.E., ATLANTA 30328

FELLNER, DONALD W. 29 ACT OR
278B BAYARD ST., EAST POINT 30344

FELNER, JOEL M. 29 A C
GRADY MEM. HOSP., ATLANTA 30303

FERGUSON, IRA A., JR. 29 ACT SL
EMORY UNIV. CLINIC, ATLANTA 30322

FERGUSON, WILSON J. 29 ACT SL
GENERAL MOTORS CORP., DORAVILLE 30340

FINUCANE, BRENDAN T. 29 A ANES
69 BUTLER ST., DEPT. ANES., ATLANTA 30303

FERRIS, HAROLD A. 29 ACT I
47B PEACHTREE ST. N. E., ATLANTA 30308

FIEDOTIN, ARNOLDO 29 ACT I
265 IVY ST., N.E., ATLANTA 30303

FINCH, CHARLES S., JR. 29 ACT ANES
2550 WINDY HILL RD., MARIETTA 30061

FINCH, HENRY M. 29 ACT PR
490 PEACHTREE ST. N. E., ATLANTA 30308

FINCHER, RONALD E. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

FINEGAN, ROBERT FRANKLIN 29 ACT ANES
2760-8 FELTON DR., EAST POINT 30344

FISH, JOHN S. 29 ACT OB
340 BOULEVARD, N. E., ATLANTA 30312

FISHER, J. EDWARD 29 ACT OBG
340 BOULEVARD, N. E., ATLANTA 30312

FISHER, WM. R. 29 ACT ALR
490 PEACHTREE ST., N. E., ATLANTA 30308

FITZHUGH, F. W., JR. 29 ACT I
193B PEACHTREE ROAD, N. W., ATLANTA 30309

FITZPATRICK, PAUL E. 29 ACT I
6185 JONESBORO RD., MORROW 30260

FLANAGAN, JAMES C. 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

FLEISHER, ALAN S. 29 ACT NS
80 BUTLER ST., SE, ATLANTA 30303

FLEMING, WILLIAM H. 29 ACT TS
1365 CLIFTON RD., N.E., ATLANTA 30322

FLETCHER, GERALD F. 29 A I
300 BOULEVARD, N. E., ATLANTA 30312

FLINCHUM, DARIUS 29 ACT OR
340 BOULEVARD, N. E., ATLANTA 30312

FLOYD, EARL H. 29 DE1 L
3705 VERMONT RD., N.E., ATLANTA 30319

FLYNN, GREGORY E. 29 ACT OPH
2550 WINDY HILL RD., UMC, MARIETTA 30062

FORBES, G. LESTER, JR. 29 ACT PATH
340 BOULEVARD, N.E., ATLANTA 30312

FORSYTH, DOUGLAS H. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

FOWLER, C. DIXON 29 ACT PD
27 EIGHTH ST. N. E., ATLANTA 30309

FOWLER, MAJOR F. 29 ACT L
2637 PEACHTREE RD., N.E., ATLANTA 30305

FRANCH, ROBERT H. 29 ACT I
EMORY UNIV. CLINIC, ATLANTA 30322

FRANCK, GEORGE H. 29 ACT IND
64 PERIMETER CTR. EAST, N.E., ATL. 30346

FRANCO, NED M. 29 ACT L
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

FRANCO, RICHARD D. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

FRANK, MILTON, III 29 ACT I
1175 PEACHTREE ST., N.E., ATLANTA 30309

FRANKLIN, ERNEST W. 29 ACT OBG
25 PRESCOTT ST., N.E., ATLANTA 30308

FRAZIER, WESLEY T. 29 ACT ANES
1365 CLIFTON RD., N.E., ATLANTA 30322

FREDERICKSON, EVAN L. 29 ACT ANES
EMORY UNIV., ANES. DEPT., ATLANTA 30322

FREEDMAN, MILTON H. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312

FREEMAN, LAWRENCE C., JR. 29 ACT ANES
355 LINDBERG DR., N. E., ATLANTA 30305

FREEMAN, MALCOLM G. 29 A OBG
463 KIRK RD., DECATUR 30030

FREEMAN, OLEN I. 29 ACT P
5064 NANDINA LN., DUNWOODY 30338

FRIEDEWALD, WM. F. 29 ACT I
1293 PEACHTREE ST., N.E., ATLANTA 30309

FULGHUM, C. B., JR. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

FULLER, GEO. W. 29 DE5 FP
263B PEACHTREE RD., N.E., ATLANTA 30305

FULMER, THOMAS E. 29 ACT P
1711 AIDMORE DR., N.E., ATLANTA 30307

FUNK, F. JAMES, JR. 29 ACT OR
193B PEACHTREE ROAD, N. W., ATLANTA 30309

FUNK, SIDNEY A. 29 ACT OBG
275 CARPENTER DR., ATLANTA 30329

FUNKHOUSER, W. L. 29 DE5 PD
47 PEACHTREE PARK DR., N.E., ATLANTA 30309

GABLE, THOMAS W. 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

GABLER, REGINA 29 ACT OBG
950 W. PEACHTREE ST. N. W., ATLANTA 30309

GALAMBOS, JOHN T. 29 ACT I
69 BUTLER ST., S.W., ATLANTA 30303

GALLOWAY, WM. H. 29 ACT OBG
340 BOULEVARD, N. E., ATLANTA 30312

GALVIN, WM. H. 29 ACT ANES
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

GAMBRELL, W. ELIZABETH 29 DE5 I
384 PEACHTREE ST. N. E., ATLANTA 30308

GAMWELL, JOHN W. 29 ACT OR
25 PRESCOTT ST., N.E., ATLANTA 30308

GARCIA, P. F. 29 ACT P
3316 PIEDMONT RD, N.E., ATLANTA 30305

GAY, BRIT B., JR. 29 ACT R
1405 CLIFTON RD., N. E., ATLANTA 30333

GAY, THOMAS BOLLING 29 DE1 PD
3042 W. PINE VALLEY RD. N.W.,ATLANTA 30305

GECKLER, JOHN H. 29 ACT ANES
20 LINDEN AVE., N.E., ATLANTA 30308

GEONEY, LEIGH M. 29 S L
818, FED. ANNEX, ATLANTA 30304

GEER, BRUCE R. 29 ACT GE
3250 HOWELL MILL RD.,NW, STE 200, AT 30327

GERMAIN, A. H. 29 OE5 FP
259 ARROWHEAD BLVD., JONESBORO 30236

GERSHON, NATHAN I. 29 ACT OALR
340 BOULEVARD, NE, ATLANTA 30312

GERTLER, PHILLIP E. 29 ACT I
1938 PEACHTREE RD., N. W., ATLANTA 30309

GERTNER, HAROLD R., JR. 29 ACT SU
1968 PEACHTREE RD., N.W., ATLANTA 30309

GHANI, CHARLES A. 29 ACT ANES
1365 CLIFTON RD., N.E., ATLANTA 30322

GHOLSON, A. R. 29 ACT ANES
180 LAUREL FOREST CIR., NE, ATLANTA 30305

GIBSON, SAM T. 29 A
FDA, BLDG. 29, RM. 118, BETHESDA,MD. 20014

GILBERT, CHARLES A. 29 ACT I
69 BUTLER ST., S. E., ATLANTA 30303

GILES, BEN J. 29 ACT ANES
384 PEACHTREE ST., N. E., ATLANTA 30308

GILLESPIE, EUGENE J. 29 A O
47 TRINITY AVE., S. W., ATLANTA 30334

GILLESPIE, ROBERT H. 29 ACT OBG
1938 PEACHTREE RD., NW, ATLANTA 30309

GILNER, DONALD M. 29 ACT AL
960 JOHNSON FERRY RD., ATL. 30342

GINSBERG, STEWART T. 29 R P
960 JOHNSON FERRY RD., ATLANTA 30033

GIRARDEAU, JOSEPH L. 29 ACT OBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

GLADSON, JAMES E. 29 ACT I
37 WILLOWICK CT., DECATUR 30034

GLASS, LAMAR F. 29 ACT SU
25 PRESCOTT ST., NW, STE. 4441, ATL 30308

GLENN, WADLEY R. 29 ACT SU
35 LINDEN AVE. N. E., ATLANTA 30308

GLISSON, C. STEADMAN 29 ACT OBG
401 PEACHTREE ST., N.E., ATLANTA 30308

GODWIN, JOHN THOMAS 29 ACT PATH
265 IVY STREET, N. E., ATLANTA 30303

GOLD, PERRY 29 A PD
2795 MRGRT MITCHELL DR., N.W., ATL. 30327

GOLDEN, HOWARD A. 29 ACT OBG
970 HUNTER ST., S. W., ATLANTA 30314

GOLDMAN, GILBERT C. 29 ACT O
5675 PTREE-DUNWOODY RD., N.E., ATL 30342

GOLDMAN, JOHN A. 29 ACT I
1365 CLIFTON RD., N.E., ATL. 30322

GOLDMAN, MILTON S. 29 ACT L
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

GOMEZ, FRANK 29 ACT SU
ARROWHEAD MEDICAL PLAZA, JONESBORO 30236

GOMEZ, JULIAN R. 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

GONZALEZ, PABLO E. 29 ACT
4508 CHERIE GLEN TRAIL, ST. MT., 30083

GONZALEZ, VICTOR R. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATL 30329

GOODWYN, THOS. P. 29 OE5 OR
2840 WOODWARD WAY, N.W., ATLANTA 30305

GORDON, STEPHEN F. 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

GRABLOWSKY, OSCAR M. 29 ACT SU
340 BOULEVARD, N.E., ATLANTA 30312

GRADY, CHARLOTTE 29 A
35 LINDEN AVE., N.E., ATLANTA 30308

GRADY, DONALD F. 29 ACT NS
1175 PEACHTREE ST., N. E., ATLANTA 30309

GRADY, EDGAR D. 29 ACT
2788 BAYARD ST., EAST POINT 30344

GRAVANIS, MICHAEL B. 29 ACT PATH
1365 CLIFTON RD., N. E., ATLANTA 30322

GRAVES, RAPHAEL K. 29 ACT PATH
1000 JOHNSON FERRY RD., N.E., ATL. 30345

GRAYDON, E. LEONARD 29 OE5 FP
101 3RD ST., N.E., ATLANTA 30308

GREEN, EDMOND W. 29 ACT FP
3395 STEWART AVE., DAPEVILLE 30354

GREENBERG, IRVING L. 29 ACT SU
950 W. PEACHTREE ST. N. W., ATLANTA 30309

GREENBERG, JOEL I. 29 ACT OBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

GREGOROFF, STANLEY 29 ACT I
384 PEACHTREE ST., N.E., ATLANTA 30308

GREGORY, HUGH H. 29 ACT SU
735 PIEDMONT AVE., N.E., ATLANTA 30308

GRIFFIN, BASIL M., JR. 29 ACT OR
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

GRIFFIN, JOHN M. 29 ACT PI
3250 HOWELL MILL RD., N.E., ATLANTA 30327

GRIMES, W. H., JR. 29 ACT OB
340 BOULEVARD, N. E., ATLANTA 30312

GRISAMORE, J. M. 29 ACT SU
6500 VERNON WOODS RD., N.E., ATLANTA 30328

GROSS, PETER R. 29 ACT I
384 PEACHTREE ST., N. E., ATLANTA 30308

GROSSMAN, GILBERT D. 29 ACT I
25 PRESCOTT ST., N.E., ATLANTA 30308

GRUSH, OWEN C. 29 ACT PD
69 BUTLER ST., S. E., ATLANTA 30303

GUDE, A. V. 29 ACT ANES
3464 PINESTREAM RD., N.W., ATLANTA 30327

GUFFIN, THOMAS N. 29 ACT SU
461 KING ARNOLD ST., DAPEVILLE 30054

GUSSACK, HAROLD A. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308

GUY, J. CANDLER 29 ACT L
3312 PIEDMONT RD., N. E., ATLANTA 30305

HACKER, MORTIMER 29 ACT PATH
1330 W. PTREE ST., N.W., ATLANTA 30309

HACKNEY, J. F. 29 DE1 PH
1611 MILL ACRES DR., S.W., ATLANTA 30311

HAGAN, JOHN C., III 29 A OPH
80 BUTLER ST., SE, ATLANTA 30303

HAGLER, WILLIAM S. 29 ACT OPH
575 W. PEACHTREE ST., N. E., ATLANTA 30308

HAILEY, CHENAULT W. 29 ACT O
478 PEACHTREE ST., N. E., ATLANTA 30308

HALL, HENRY L. 29 ACT P
EMORY UNIVERSITY, ATLANTA 30322

HALL, JOHN C. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

HALLMAN, B. L. 29 ACT I
80 BUTLER ST., S.E., ATLANTA 30303

HALLMAN, HELEN W. 29 ACT ANES
159 FORREST AVE., N.E., ATLANTA 30303

HALLUM, ALTON V. 29 OE5 OPH
3280 HOWELL MILL RD., N.W., 207 ATL 30327

HALLUM, ALTON V., JR. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

HALTIWANGER, EARL 29 S L
1670 CLAIRMONT RD., N. E., ATLANTA 30329

HAMFF, LEONARD H. 29 ACT I
478 PEACHTREE ST. N. E., ATLANTA 30308

HAMM, WM. G. 29 OE5 PL
1938 PEACHTREE RD., N.W., ATLANTA 30309

HAMMONDS, WILLIAM O. 29 ACT ANES
1365 CLIFTON RD., NE, ATLANTA 30322

HANCOCK, CHARLES I. 29 ACT OR
340 BOULEVARD, N.E., ATLANTA 30312

HANCOCK, ROBERT K. 29 ACT OBG
490 PEACHTREE ST., N.E., ATLANTA 30308

HANES, O. EUGENE 29 ACT I
600 W. PEACHTREE ST. N. E., ATLANTA 30308

HANKEY, DANIEL O. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308

HANNER, JAMES P. 29 OE5 PD
49-26TH ST., N. E., ATLANTA 30309

HANSEN, ROBERT F. 29 S
2 EMMA LN., N.E., ATLANTA 30305

HARASZTI, ALEXANDER 29 ACT SU
217 ARROWHEAD BLVD., JONESBORO 30236

HARASZTI, ROSALIE 29 ACT FP
217 ARROWHEAD BLVD., JONESBORO 30236

HARDIN, FREDERICK F. 29 ACT O
1938 PEACHTREE RD., N. W., ATLANTA 30309

HARLIN, JOYCE A. 29 A R
80 BUTLER ST., S. E., ATLANTA 30303

HARPER, BYRON F., JR. 29 ACT I
2741 BAYARD ST., EAST POINT 30344

HARPER, CHARLES R. 29 ACT AM
P. O. BOX 20787, ATLANTA 30320

HARPER, WILLIAM N. 29 ACT FP
75 PIEDMONT AVE., N.E., ATLANTA 30303

HARRIS, BOAZ 29 ACT P
490 PEACHTREE STREET, NE, ATLANTA 30308

HARRIS, J. FRANK 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308

HARRIS, JAMES B. 29 ACT OBG
1478 MOZLEY DR., S.W., ATLANTA 30314

HARRIS, MICHAEL N. 29 ACT FP
400 COLONY SQ. #1505, ATLANTA 30361

HARRIS, T. A. 29 ACT OBG
340 BOULEVARD, N. E., ATLANTA 30312

HARRISON, CHARLES E., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

HARRISON, EUGENE O. 29 ACT SU
340 BOULEVARD, N. E., ATLANTA 30312

HARRISON, JAMES HAROLD 29 ACT
490 PEACHTREE ST. N. E., ATLANTA 30308

HARTLEY, JOHN H., JR. 29 ACT PL
1938 PEACHTREE RD., N. W., ATLANTA 30309

HARTRAMPF, CARL R. 29 ACT PL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

HASTY, LEWIS B. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344

HATCHER, CHARLES R. 29 ACT TS
EMORY CLINIC, ATLANTA 30322

HATHCOCK, WM. C. 29 ACT OALR
401 PEACHTREE ST., N.E., ATLANTA 30308

HAUCK, A. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308

HAUGEN, HARRY T. 29 ACT FP
2391 SEWELL RD., S.W., ATLANTA 30311

HAUN, COSMO L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322

HAVERTY, JOHN RHODES 29 ACT PD
UNIVERSITY PLAZA, ATLANTA 30303

HAWK, JUDSON LOUIS, JR. 29 ACT PD
3162 PIEDMONT RD., N. E. ATLANTA 30305

HEARIN, DAVID L. 29 ACT O
3158 MAPLE DR. N. E., ATLANTA 30305

HECHT, HOWARD L. 29 ACT OR
6500 VERNON WOODS DR., D-22, AT 30328

HEILMAN, RICHARD B. 29 ACT INO
BOX 13083, ATLANTA 30310

HEIN, DAVID E. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312

HENDEE, ARMAND ELKIN 29 ACT OBG
EMORY UNIVERSITY CLINIC, ATLANTA 30322

HENDRIX, VERNON J. 29 ACT OBG
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

HENRY, J. LAMONT 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

HERNANDEZ, R. J. 29 ACT ANES
384 PEACHTREE ST., N. E. ATLANTA 30308

HERNDON, EUCLID G., JR. 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322

HERSH, THEODORE 29 ACT GE
1365 CLIFTON RD., N. E., ATLANTA 30322

HERTELL, JOSEPH A. 29 ACT I
3001 N. FULTON DR., N.E., ATLANTA 30305

HEWELL, GUY C. 29 OE5 OBG
1123 BERKSHIRE RD., N.E., ATLANTA 30306

HILL, JULIUS N., III 29 ACT ANES
384 PEACHTREE ST., N.E., ATLANTA 30308

HILL, WM. H. 29 ACT SU
710 PEACHTREE ST. N. E., ATLANTA 30308

HILLIS, CHARLES L. 29 ACT FP
P. O. BOX 846, LAFAYETTE 30728

HILSMAN, A. H., III 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

HILSMAN, J. H. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

HIRT, ALFREDO 29 ACT L
490 PEACHTREE ST., N. E., ATLANTA 30308

HLEAP, DAVID 29 ACT FP
4555 N. SHALLOWFORD RD., ATLANTA 30342

HOBBY, A. WORTH 29 DE5 PUL
490 PEACHTREE ST., N.E., ATLANTA 30308

HOBBY, LOVIC W. 29 ACT SU
35 COLLIER RD., N.W., ATLANTA 30309

HOCKENHULL, JOHN A. 29 ACT FP
P. O. BOX 188, NICHOLLS 31544

HOFFMAN, BYRON J. 29 ACT I
768 JUNIPER ST. N. E., ATLANTA 30308

HOFFMAN, JAMES C., JR. 29 ACT R
1365 CLIFTON RD., N. E., ATLANTA 30322

HOLLAND, BERNARD C. 29 ACT P
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

HOLLOWAY, CHAS. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308

HOLLOWAY, GEORGE A. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

HOLTON, JOHN B. 29 ACT R
35 BUTLER ST., S.E., ATLANTA 30303

HOPKINS, WM. A. 29 ACT SU
1938 PEACHTREE RD., N. W. 303, ATL 30309

HORNBERGER, R. B. 29 ACT PATH
340 BOULEVARD, N. E., ATLANTA 30312

HOTALEN, WM. B. 29 ACT IND
3384 PTREE RD., N.E., ATLANTA 30326

HOWARD, CHARLES K. 29 A SU
5084 N. PEACHTREE, DUNWOODY 30338

HOWARD, JAMES W. 29 ACT FP
849 BATTLE CREEK RD., JONESBORO 30236

HOWELL, BARBARA P. 29 ACT FP
620 PEACHTREE ST., N.E., ATLANTA 30308

HOWELL, TOM S., JR. 29 ACT SU
620 PEACHTREE ST., N.E., ATLANTA 30308

HOWLAND, W. SLOCUM, JR. 29 ACT OR
3250 HOWELL MILL RD., NW., ATLANTA 30327

HUBBARD, DONALD E. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

HUGGINS, HERBERT A. 29 S PH
50 SEVENTH ST., N.E., ATLANTA 30323

HUDGINS, WILLIAM BAIRD 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

HUG, CARL C., JR. 29 ACT ANES
69 BUTLER ST., S.E., ATLANTA 30303

HUGER, WILLIAM, JR. 29 ACT PL
35 COLLIER RD., N.W., ATLANTA 30309

HUGHES, D. JAMES 29 ACT I
755 COLUMBIA DR., DECATUR 30030

HUGHES, JOE L. 29 ACT CR
1311 CLEVELAND AVE., EAST POINT 30344

HUGULEY, CHAS. M., JR. 29 ACT I
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

HUIE, RALPH A., JR. 29 ACT I
774 CLEMONT RD., N.E., ATLANTA 30306

HUMPHREYS, JOHN L. 29 ACT OPH
705 JUNIPER ST., N.E., ATLANTA 30308

HUNTER, CONWAY W., JR. 29 ACT OBG
3250 HOWELL MILL RD., N.W., ATLANTA 30327

HURO, RICHARD A., JR. 29 A OR
145 COPELAND RD., E-2, ATLANTA 30342

HURST, J. WILLIS 29 ACT I
69 BUTLER ST., S.E., ATLANTA 30303

HUTCHINSON, J. R. B. 29 ACT OTO
144 PONCE DE LEON AVE., N.E., ATLANTA 30308

HYDRICK, JOHN T. 29 ACT OBG
960 JOHNSON FRY. RD., STE 245, ATL 30342

HYDRICK, PETER 29 ACT OBG
2744 FELTON DR., EAST POINT 30344

HYERS, JOHN J. 29 ACT ANES
5 CHAUMNT SQ, CROSS CRK PKY, NW, ATL. 30327

HYMAN, BARRY N. 29 OE2 OPH
10119 BRIAR FOREST, HOUSTON, TX 77042

ISENBERG, SIDNEY 29 ACT P
44 25TH ST., N.E., ATLANTA 30309

IVEY, JOHN C. 29 OE5 SU
BOX 309, MEANSVILLE 30021

IZENSTARK, JOSEPH L. 29 A R
80 BUTLER ST. S.E., ATLANTA 30303

JACKSON, ZACH W. 29 DE5 OPH
1956 N. RIDGEWAY RD., N.E., ATLANTA 30345

JACOBS, JOHN L. 29 ACT AL
490 PEACHTREE ST., N.E., ATLANTA 30308

JACOBS, JULIAN 29 S I
VA HOSP., P. O. BOX 29457, ATLANTA 30329

JAFFE, STEVEN L. 29 ACT P
6500 VERNON WOODS DR., N.E., ATLANTA 30328

JAMES, W. SCOTT 29 ACT PD
275 CARPENTER DR., N.E., ATLANTA 30328

JARMAN, JULIAN A. 29 S SU
P. O. BOX 29457, ATLANTA 30329

JARRETT, WM. H. 29 ACT OPH
575 W. PEACHTREE ST., N. E., ATLANTA 30308

JARVIS, JACK R. 29 S P
P. O. BOX 29457, ATLANTA 30329

JERNIGAN, STERLING H. 29 ACT SU
710 PEACHTREE ST., N.E., ATLANTA 30308

JOEL, CHARLES, JR. 29 S N
1670 CLAIRMONT RD., N.E., DECATUR 30033

JOHNSON, CHARLES E. 29 ACT I
3250 HOWELL MILL RD., N.E., ATLANTA 30342

JOHNSON, CHARLES G. 29 ACT FP
4932 PHILLIPS DR., FOREST PARK 30050

JOHNSON, C. V. 29 ACT P
2151 PEACHFORD RD., ATLANTA 30341

JOHNSON, EDWARD D. 29 ACT SU
3450 INTERNATIONAL BLVD., HAPEVILLE 30354

JOHNSON, HENRY C., JR. 29 ACT R
35 COLLIER RD., N. W., ATLANTA 30309

JOHNSON, L. MALCOLM 29 ACT FP
3450 INTERNATIONAL BLVD., HAPEVILLE 30354

JOHNSON, MCCLAREN 29 ACT GE
478 PEACHTREE ST., N.E., ATLANTA 30308

JOHNSON, R. JULIAN 29 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

JOHNSON, RICHARD HARDIN 29 ACT I
2045 PEACHTREE RD., N.E., ATLANTA 30309

JOINES, IVERSON W., II 29 ACT I
478 PEACHTREE ST., N.E., ATLANTA 30308

JOLLEY, FLEMING L. 29 ACT NS
EMORY CLINIC BUILDING, ATLANTA 30322

JONES, ARTHUR B., JR. 29 ACT OBG
401 PEACHTREE ST., N.E., ATLANTA 30308

JONES, CARL C., JR. 29 ACT AL
1285 PEACHTREE ST., N.E., ATLANTA 30309

JONES, CHARLES M. 29 A FP
NO CURRENT ADDRESS

JONES, E. LADD, JR. 29 ACT OR
3250 HOWELL MILL RD., N.W., ATLANTA 30327

JONES, ELLIS L. 29 A TS
EMORY UNIV. SCH. OF MED., ATLANTA 30322

JONES, GEORGE W., JR. 29 ACT I
490 PEACHTREE ST., N. E., ATLANTA 30308

JONES, HERMAN D., PH.D. 29 H
DIR. CRIME LAB., P.O. BOX 1456, ATL 30301

JONES, LEWIS E. 29 S I
1670 CLAIRMONT RD., DECATUR 30033

JONES, MERWOOD M. 29 ACT OBG
2945 STONE HOGAN RD., CONN., ATL. 30331

JONES, RICHARD B. 29 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

JORDAN, W. DANIEL 29 ACT SU
490 PEACHTREE ST., STE 365-C, ATL 30308

JOSEPH, ALFRED 29 ACT PO
1311 CLEVELAND AVE., EAST POINT 30344

JOSEPH, A. HAROLD 29 ACT L
3316 PIEDMONT RD., N.E., ATLANTA 30305

JOSEPHS, ALVIN O. 29 S I
P. O. BOX 29457, ATLANTA 30329

JOSEY, WILLIAM E. 29 ACT OBG
1365 CLIFTON RD., N.E., ATLANTA 30322

JOVE, DONNA F. 29 ACT PATH
1216 ARBOR VISTA DR., N.E., ATLANTA 30329

JURKIEWICZ, MAURICE J. 29 ACT PL
1365 CLIFTON RD., N.E., ATLANTA 30322

KAHLE, DAN BRUCE 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

KAHN, S. DAVID 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

KAPLAN, JOEL A. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322

KARASU, SUAT 29 ACT ANES
627 CHEROKEE ST., MARIETTA 30060

KARP, HERBERT R. 29 ACT N
69 BUTLER STREET, SE, ATLANTA 30303

KATZ, MYRON M. 29 ACT OBG
259 ARROWHEAD BLVD., JONESBORO 30236

KAUFMANN, GARY E. 29 ACT NS
2550 WINDY HILL RD., S.E., MARIETTA 30062

KAUFMANN, JAMES A. 29 ACT I
950 W. PEACHTREE ST. N. W., ATLANTA 30309

KELLEY, W. A. 29 OE5 FP
478 PEACHTREE ST., N.E., ATLANTA 30308

KELLY, JAMES O. 29 R SU
GENERAL MOTORS CORP., DORAVILLE 30340

KELLY, ROBERT P., JR. 29 ACT OR
1365 CLIFTON RD., N. E., ATLANTA 30322

KEMPER, CLIFTON G. 29 OE5 FP
478 PEACHTREE ST., N.E., ATLANTA 30308

KENDRICK, DOUGLAS B. 29 A SU
3217 TETON DR., N.W., ATLANTA 30339

KETRON, HUBERT W. 29 S I
304 WORTHINGTON DR., MARIETTA 30060

KIBLER, ROBERT F. 29 ACT I
69 BUTLER ST., S. E., ATLANTA 30303

KILEY, JAMES O. 29 ACT I
3250 HOWELL MILL RD., N.E., ATLANTA 30327

KILPATRICK, WM. H. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344

KIM, CHYUNG M. 29 ACT PD
1468 S. INDIAN CREEK DR., ST. MT. 30083

KIM, H. HANK 29 ACT PD
2788 BAYARD ST., EAST POINT 30344

KIM, JONG-IN 29 ACT ANES
2760 FELTON DR., EAST POINT 30344

KING, C. RICHARD 29 ACT SU
35 COLLIER RD., N.W., ATLANTA 30309

KING, JAMES T. 29 OE1 ALR
3250 HOWELL MILL RD., N.W., ATLANTA 30327

KING, JAMES T., JR. 29 DE2 SU
14 INDEPENDENCE PLACE, ATLANTA 30318

KING, J. OUDLEY 29 ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

KING, RICHARD E. 29 ACT OR
340 BOULEVARD, N. E., ATLANTA 30312

KING, SPENCER B., III 29 ACT C
EMORY UNIV. CLINIC, ATLANTA 30322

KING, STEPHEN 29 ACT PD
6500 VERNON WOODS DR., ATLANTA 30328

KIRCHNER, ARTHUR B. 29 ACT R
GRADY MEM. HOSP., ATLANTA 30303

KISER, ELLEN FINLEY 29 DE5 P
210 PEACHTREE CIR., N. E., ATLANTA 30309

KISER, WM. H., JR. 29 DE5 P
210 PEACHTREE CIR., N. E., ATLANTA 30309

KITAY, DAVID Z. 29 A OBG
80 BUTLER ST., S.E., ATLANTA 30303

KITE, J. H. 29 DE5 OR
490 PEACHTREE ST. N. E., ATLANTA 30308

KLAUS, RICHARD M. 29 ACT OR
2550 WINDY HL. RD., STE. 208, MARIET 30062

KLEIN, LUELLA M. 29 ACT OBG
80 BUTLER ST., S. E., ATLANTA 30303

KLERIS, GEORGE S. 29 A PH
220 FORREST LK. DR., N.W., ATLANTA 30327

KLOPPER, RALPH M. 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

KLOPSTOCK, WILLIAM J. 29 ACT P
3316 PIEDMONT RD., N.E., ATLANTA 30305

KLOTZ, HUGH A. 29 ACT OPH
3316 PIEDMONT RD., N.E., ATLANTA 30305

KLUGH, GEORGE F. 29 OE5 PATH
303 N. HORNER BLVD., SANFORD, N. C. 27730

KOENIG, RONALD H. 29 ACT N
2739 FELTON DR., EAST POINT 30344

KONAKCI, YUKSEL 29 A PATH
NO CURRENT ADDRESS

KRAININ, MILTON JOSEPH 29 ACT I
1293 PEACHTREE ST., N.E., ATLANTA 30309

KRAL, ROBERT A. 29 ACT OBG
2100 PARKLAKE DR., N.E., ATLANTA 30345

KRAMER, JOHN H. 29 ACT OPH
4555 N. SHALLOWFORD RD., ATLANTA 30341

KRANTZ, SIMON 29 S R
1670 CLAIRMONT RD., N. E., ATLANTA 30329

KRAVITZ, ALAN E. 29 ACT I
1938 PEACHTREE RD., N.W., ATLANTA 30309

KRUGMAN, PHILIP I. 29 ACT OBG
3312 PIEDMONT RD., N.E., ATLANTA 30305

KUMIN, GERALD D. 29 ACT I
644 CHEROKEE ST., MARIETTA 30062

KURTZ, JOSEPH L. 29 ACT OR
401 PEACHTREE ST., N.E., ATL. 30308

KUTNER, STEPHEN S. 29 ACT OPH
340 BOULEVARD, N.E., ATLANTA 30312

LACKEY, DIXON A. 29 ACT PD
47 TRINITY AVE. S.W., ATLANTA 30334

LAHMAN, ROSE A. 29 ACT OBG
950 W. PEACHTREE ST., N. W., ATLANTA 30309

LAMIS, PANO A. 29 ACT SL
314 BOULEVARD, N. E., ATLANTA 30312

LANDY, MICHAEL S. 29 ACT I
2739 FELTON DR., EAST POINT 30344

LANE, DONALD R. 29 ACT I
353 PARKWAY DR., N. E., ATLANTA 30312

LANGFORD, JAMES F. 29 ACT FP
1143 ALPHARETTA ST., ROSWELL 30075

LANIER, BOB G. 29 ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

LARAMORE, HERBERT F. 29 A PH
654 KIMBERLY LANE, N.E., ATLANTA 30306

LAROCHE, LAURENT P. 29 ACT OCM
2000 N.E. X-WAY, NORCROSS 30071

LAROSE, JAMES H. 29 ACT R
1170 CLEVELAND AVE., ATLANTA 30344

LATHAM, ELIZABETH B. 29 ACT PD
3185 WASHINGTON RD., EAST POINT 30344

LATHAN, SAMUEL R. 29 ACT I
1201 PTREE ST., N.E., ATLANTA 30361

LAVIETES, PAUL A. 29 ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

LAWRENCE, GEORGE C. 29 ACT OBG
75 PIEDMONT AVE., N. E., ATLANTA 30303

LEE, DOROTHY S. JAEGER 29 ACT PD
1365 CLIFTON RD., N.E., ATLANTA 30322

LEE, JOHN E. 29 ACT N
3312 PIEDMONT RD., N.E., ATL. 30305

LEFKOFF, HAROLD J. 29 ACT OALR
340 BOULEVARD, N.E., ATLANTA 30312

LEHMAN, RONALD J. 29 ACT OR
4555 N. SHALLOWFORD RD, CHAMBLEE 30341

LEIGH, TED F. 29 ACT R
1365 CLIFTON RD., N. E., ATLANTA 30322

LELAND, TOM W. 29 ACT P
2905 PEACHTREE RD., N.E., ATLANTA 30305

LENTON, JOHN O. 29 ACT I
490 PEACHTREE ST., N. E., ATLANTA 30308

LEONARD, JAMES R. 29 ACT OTO
3250 HOWELL MILL RD., N. W., ATLANTA 30327

LEONARD, ROBERT P. 29 ACT PL
960 JOHNSON FERRY RD.,N.E., ATLANTA 30342

LEONARD, WILLIAM P. 29 ACT SU
3406 OLD PLANTATION RD., N.W., ATL 30327

LEONARDY, JOHN G. 29 ACT I
478 PEACHTREE ST., N.E., ATLANTA 30308

LESESNE, ARTHUR E. 29 ACT I
353 PARKWAY, N.E., ATLANTA 30312

LESSER, JOSEPH M. 29 ACT FP
490 PEACHTREE ST., N. E., ATLANTA 30308

LESTER, JESS C. 29 ACT OPH
478 PEACHTREE STREET, N.E., ATLANTA 30308

LESTER, WM. M. 29 ACT OB
340 BOULEVARD, N.E., ATLANTA 30312

LETTON, A. HAMBLIN 29 ACT SU
315 BOULEVARD, N. E., ATLANTA 30312

LEVIN, HAROLD B. 29 ACT O
1293 PEACHTREE ST., N.E., ATLANTA 30309

LEVIN, JACK M. 29 ACT PR
340 BOULEVARD, N. E., ATLANTA 30312

LEVIN, RICHARD LESLIE 29 ACT O
3228 BRISTOL RD., CORNWELLS HGT., PA 19020

LEVINE, MICHAEL K. 29 ACT PO
6500 VERNON WOODS DR., N.E., ATLANTA 30328

LEVINE, STANLEY H. 29 ACT OBG
3312 PIEDMONT RD., N. E., ATLANTA 30305

LEVINE, STEPHEN B. 29 ACT PO
5675 PEACHTREE-DUNWDY RD., N.E., ATL 30342

LEVY, CHARLES E. 29 ACT P
3400 PEACHTREE ST., N.E., ATLANTA 30326

LEVY, LOUIS K. 29 ACT I
1938 PEACHTREE RD., NW, ATLANTA 30309

LEVY, MOREND Y. 29 OE5 FP
221 ROBINHOOD RD., N.E., ATLANTA 30309

LEWIS, ERNEST L. 29 ACT U
1365 CLIFTON RD., N. E., ATLANTA 30322

LEWIS, JOHN R., JR. 29 ACT PL
3316 PIEDMONT RD., N.E., ATLANTA 30305

LICHTMAN, STANLEY 29 ACT ANES
2760 FELTON DR., EAST POINT 30344

LIEVANO, ALVARO 29 ACT OR
1203 CLEVELAND AVE., EAST POINT 30344

LIN, HUI-CHING Y. 29 A I
634 WILSON RD., N.W., ATLANTA 30318

LINDSEY, I. LEHMAN, JR. 29 ACT R
3312 PIEDMONT RD., N. E., ATLANTA 30305

LIPMAN, BERNARD S. 29 ACT I
1285 PEACHTREE ST., N.E., ATLANTA 30309

LIPSCOMB, J. WATTS 29 ACT I
6185 JONESBORO RD., MORROW 30260

LIPSCOMB, THOMAS L. 29 ACT
3450 INTERNATIONAL BLVD., HAPEVILLE 30354

LOCHRIDGE, EDWIN P., JR. 29 ACT PR
35 COLLIER RD., N.W., ATLANTA 30309

LOFTMAN, BERT A. 29 ACT N
2718 FELTON DR., EAST POINT 30344

LOGAN, WILLIAM DEWEY, JR. 29 ACT TS
272 BOULEVARD, N.E., ATLANTA 30312

LOGUE, R. BRUCE 29 ACT I
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

LONG, STEWART M. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

LONG, WILLIAM B. 29 ACT OPH
4303 LAVISTA RD., TUCKER 30084

LOPEZ, JOSE 29 ACT ANES
33 SW UPPER RIVERDALE RD., RIVERDALE 30274

LOPEZ, ORLANDO O. 29 ACT U
2748 FELTON DR., EAST POINT 30344

LORD, CLYDE O. 29 ACT ANES
501 FAIRBURN RD., S. W., ATLANTA 30331

LOUGHLIN, EDWARD C. 29 ACT OR
3316 PIEDMONT RD., N.E., ATLANTA 30305

LOVELL, WOOD W. 29 ACT OR
321 W. HILL ST., DECATUR 30030

LOWANCE, DAVIC C. 29 ACT I
1201 PEACHTREE ST., N.E., ATLANTA 30361

LOWANCE, MASON I. 29 ACT AL
3312 PIEDMONT RD., N. E., ATLANTA 30305

LOWENBERG, ROBERT I. 29 ACT SU
4444 AUSTELL RD., AUSTELL 30001

LUCAS, GEORGE W. 29 ACT SL
340 BOULEVARD, N.E., ATLANTA 30312

LUNSFORD, GUY G. 29 OE5 RET
2457 DREW VALLEY RD. N. E., ATLANTA 30319

LYON, DAVID B. 29 ACT P
490 PEACHTREE ST., N. E., ATLANTA 30308

LYON, HARRY C. 29 ACT FP
537 MORELAND AVENUE, S.E., ATLANTA 30316

LYON, JAMES B. 29 ACT OBG
2151 PEACHFORD RD., ATLANTA 30341

MABON, ROBERT 29 ACT NS
35 COLLIER RD., N.W., ATLANTA 30309

MACDONELL, FRANK S. 29 ACT O
384 PEACHTREE ST., N.E., ATLANTA 30308

MACHADO, M. D. 29 ACT ANES
1676 MULKEY RD., AUSTELL 30001

MACRIS, ALLEN G. 29 ACT TS
490 PEACHTREE ST., N. E., ATLANTA 30308

MACWILLIAMS, PETER 29 ACT O
1000 ATL. WEST BLVD., LITHIA SPRINGS 30057

MAHAN, THOMAS P. 29 ACT ANES
3518 PACES PLACE, N. W., ATLANTA 30305

MAJOROS, MARTON 29 ACT ALR
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

MALLORY, JAMES O., JR. 29 ACT P
3355 LENOX RD., N. E., ATLANTA 30326

MALONE, THOMAS P. 29 ACT P
6363 ROSWELL RD., N. E., ATLANTA 30328

MALOY, WILLIAM C. 29 ACT I
272 BOULEVARD, N.E., ATLANTA 30312

MANCHESTER, THOS. P., JR. 29 ACT OPH
35 COLLIER RD., N.W., ATLANTA 30309

MANGET, J. O., JR. 29 OE1 FP
26 THIRD ST., N.W., ATLANTA 30308

MANIS, ROBERT 29 ACT P
NO CURRENT ADDRESS

MANSOUR, KAMAL A. 29 ACT TS
1365 CLIFTON RD., N.E., ATLANTA 30322

MARCUCCI, MIGUEL A. 29 ACT VS
2404 AUSTELL RD., AUSTELL 30001

MARCUS, NEAL W. 29 ACT OR
321 W. HILL ST., DECATUR 30030

MARINE, WILLIAM M. 29 A I
69 BUTLER ST. S.E., ATLANTA 30303

MARKS, THOMAS W. 29 ACT OR
340 BOULEVARD, N. E., ATLANTA 30312

MARTIN, ELISABETH 29 ACT OBG
P. O. BOX 946, CUMMING 30130

MARTIN, J. D., JR. 29 A SL
230 ROBIN HOOD RD., N.E., ATLANTA 30309

MARTIN, LOUIS G. 29 ACT R
793 CLIFTON RD. N.E., ATLANTA 30307

MARTIN, WILLIAM O., III 29 ACT OPH
1938 PEACHTREE RD., N. W., ATLANTA 30309

MASON, EDWARD MCK. 29 ACT SL
315 BLVD. N. E. STE. 532, ATLANTA 30312

MASON, W. ROY 29 ACT
EMORY UNIV. DEC. OF UNIV. PHY., ATL 30322

MASON, WILLIAM ALFRED 29 A PH
118 MARIETTA ST., N. W., ATLANTA 30303

MASSEE, JOSEPH C. 29 OE5 I
21 8TH ST. N. E., ATLANTA 30309

MASSEY, JOE B. 29 ACT OBG
960 JOHNSON FERRY RD., ATLANTA 30342

MATHEWS, WILLIAM H. 29 A PATH
EMORY UNIV-PATH DEPT., ATLANTA 30322

MATTHEWS, SANFORD JOHN 29 ACT PD
1938 PEACHTREE ROAD, N. W., ATLANTA 30309

MAUGHON, JAMES S. 29 ACT SU
300 BLVD., N.E., ATLANTA 30312

MAULDIN, JOHN T. 29 ACT SL
315 BLVD. N. E., STE. 528, ATLANTA 30312

MAYER, W. BREM, JR. 29 ACT N
3312 PIEDMONT RD., N. E., ATLANTA 30305

MAYS, J. LAMAR 29 ACT OPH
3200 HOWELL MILL RD., N.W., ATLANTA 30327

MCCAIN, JOHN R. 29 ACT OBG
25 PRESCOTT ST., N. E., ATLANTA 30308

MCCLELLAN, M. M., JR. 29 ACT PD
3776 DUMBARTON RD., N.W., ATLANTA 30327

MCCLELLAND, W. SPENCE 29 ACT I
478 PEACHTREE ST., N. E., ATLANTA 30308

MCCLURE, JOHN N. 29 ACT SL
25 PRESCOTT ST., N. E., ATLANTA 30308

MCCLURE, ROBERT E. 29 DE1
9201 S.W. 45TH ST., MIAMI, FLA. 33165

MCCORD, CLINTON O., JR. 29 ACT OPH
3280 HOWELL MILL RD., N. W., ATLANTA 30327

MCCORD, DALE L. 29 ACT R
25 PRESCOTT ST., N. E., ATLANTA 30308

MCCOY, JOHN M. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

MCCREE, OTIS W. 29 ACT FP
2945 STONE HOGAN RD., CONN. S.W. 30331

MCCROSKEY, MARION M. 29 ACT ANES
144 PONCE DE LEON AVE.,N.E., ATLANTA 30308

MCDANIEL, J. G. 29 DE5 SL
820 W. WESLEY RD., N.W., ATLANTA 30327

MCDANIEL, JAMES S. 29 S OBG
3043 WESTMINSTER CIR. N. W., ATL 30327

MCDONALD, H. P. 29 DE5 L
98 CURRIER ST., N. E., ATLANTA 30308

MCDONALD, LEWIS H. 29 ACT SL
490 PEACHTREE ST., N.E., ATLANTA 30308

MCDONALD, LAWRENCE P. 29 ACT L
1641 LONGWORTH OFC. BL., WASHINGTON 20515

MCDONALD, ROBERT L. 29 ACT P
3390 PEACHTREE RD., N. E., ATLANTA 30326

MCDONOUGH, L. ALLEN 29 ACT PD
1036 LINDBERG DRIVE, N. E., ATLANTA 30324

MCDOUGALL, WM. L., JR. 29 ACT L
3250 HOWELL MILL RD., N.W., ATLANTA 30327

MCFADDEN, I. J., II 29 ACT P
6500 VERNON WOODS DR., N.E., ATLANTA 30328

MCFARLIN, DALE E. 29 A I
69 BUTLER ST., S.E., ATLANTA 30303

MCGARITY, WM. C. 29 ACT SU
1365 CLIFTON RD., N. E., ATLANTA 30322

MCGINTY, A. PARK 29 ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

MCGRAW, WALKER C. 29 ACT SU
4555 N. SHALLOWFORD RD., ATLANTA 30341

MCKENZIE, WM. J., JR. 29 ACT OBG
1365 CLIFTON RD., N. E., ATLANTA 30322

MCKINNEY, ALEXANDER S. 29 ACT N
1365 CLIFTON RD., N. E., ATLANTA 30322

MCLARTY, WILLIAM T., JR. 29 ACT P
1970 CLIFF VALLEY RD., N.E., ATLANTA 30329

MCLEAN, DONALD C. 29 ACT AL
1938 PEACHTREE RD., N.W., ATLANTA 30309

MCLENDON, F. EARL 29 ACT FP
75 PIEDMONT AVE., N.E., ATLANTA 30303

MCLEOD, WALLACE N. 29 ACT D
340 BOULEVARD, N.E., ATLANTA 30312

MCNIECE, ESTELLE 29 DE5 PD
11 SEVENTEENTH ST., N.E., ATLANTA 30309

MCNINCH, JOSEPH H. 29 A ADM
4565 ANGELO DR., N.E., ATLANTA 30319

MCPHEETERS, HAROLD L. 29 ACT P
130 SIXTH ST., N. W., ATLANTA 30313

MEEHAN, PETER L. 29 DE4 OR
13913 FLINT ROCK RD., ROCKVILLE, MD. 20853

MELTZER, HAROLD D. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344

MENDELOFF, JOSEPH 29 S PATH
1670 CLAIRMONT RD., N. E., ATLANTA 30329

MERLIN, HARVEY E. 29 ACT U
2788 BAYARD ST., ATLANTA 30344

MERRILL, ARTHUR J., JR. 29 ACT C
35 LINDEN AVE., ATLANTA 30308

MILLEDGE, ROBERT O. 29 ACT R
1968 PEACHTREE RD., N.W., ATLANTA 30309

MILLER, GEORGE O. 29 ACT D
275 CARPENTER DR., N. E., ATLANTA 30328

MILLER, JOSEPH I. 29 ACT C
25 PRESCOTT ST. N. E., ATLANTA 30308

MILLER, LILA BONNER 29 ACT I
768 JUNIPER STREET, NE, ATLANTA 30308

MILLER, PRESTON R. 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

MINNICH, WM. R. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

MINOR, H. W. 29 DE5 I
4665 PEACHTREE DUNWOODY RD., ATLANTA 30342

MINOR, JAMES B. 29 ACT I
960 JOHNSON FERRY RD. N.E., ATLANTA 30342

MITCHELL, JAMES K., JR. 29 ACT ALR
6075 ROSWELL RD., N. W., ATLANTA 30328

MITCHELL, MARVIN A. 29 ACT SU
3250 HOWELL MILL RD., ATLANTA 30327

MITCHELL, OTIS C. 29 ACT OBG
217 ARROWHEAD BLVD., JONESBORO 30236

MITCHELL, WM. E. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

MITCHELL, WM. E., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

MOKAL, ALBERT J. 29 ACT R
35 LINDEN AVE., N.E., ATLANTA 30309

MOLKNER, KENNETH C. 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

MONCRIEF, W. M. 29 DE5 FP
3293 HUNTERDON WAY-SOMERSET,MARIETTA 30062

MONFORT, JOHN M. 29 DE5 I
HILTON HEAD ISLAND, S.C. 29928

MOORE, B. WALDO, JR. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

MOORE, G. RICHARD 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344

MOORE, W. W. 29 ACT NS
1175 PEACHTREE ST., N.E., ATLANTA 30309

MOORHEAD, CHRISTIAN R. 29 ACT OBG
75 PIEDMONT AVE., N.E., ATLANTA 30303

MORAN, MARTIN J. 29 ACT PD
275 CARPENTER DR., N. E., ATLANTA 30328

MORGAN, HORACE L. 29 ACT PM
1718 PEACHTREE RD., N.W., ATLANTA 30309

MORGAN, JAMES W. 29 ACT SU
490 PEACHTREE ST., N.E., ATLANTA 30308

MORRIS, ALBERT L. 29 ACT FP
65 W. CAMPBELLTON, FAIRBURN 30213

MORRISON, WILLIAM N. 29 ACT U
340 BOULEVARD, N. E., ATLANTA 30312

MORTON, WILLIAM J. 29 ACT U
3646 CHAMBLEE TUCKER RD., CHAMBLEE 30341

MOSTELLAR, MARVOUS E. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

MOYER, LEROY N. 29 ACT OBG
1175 PEACHTREE ST., N.E., ATLANTA 30309

MUNNA, JOHN C. 29 ACT PL
3316 PIEDMONT RD., N.E., ATLANTA 30305

MUNOZ, JUANA L. 29 ACT PD
2732-B FELTON DR., EAST POINT 30344

MURPHY, MICHAEL V., JR. 29 ACT I
21 8TH ST., N.E., ATLANTA 30309

MURPHY, RALPH A., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

MURRAY, DOUGLAS R. 29 ACT SL
1365 CLIFTON RD., N. E., ATLANTA 30322

NAHMIAS, ANDRE J. 29 A PD
69 BUTLER ST., S.E., ATLANTA 30303

NAPOLI, VICTOR M. 29 ACT PATH
80 BUTLER ST., S.E., ATLANTA 30303

NASH, H. E., SR. 29 DE5 FP
250 AUBURN AVENUE, N.E., ATLANTA 30303

NASSAR, G. F. 29 ACT OBG
2739 FELTON DR., EAST POINT 30344

NEELD, JOHN B. 29 ACT ANES
2620 MEADOWLAWN DR., MARIETTA 30062

NEELY, F. LEVERING 29 ACT I
1938 PEACHTREE RD., NW, ATL 30309

NEWSOM, NEAL H. 29 ACT OBG
2045 PEACHTREE RD., N.E., ATLANTA 30309

NEWTON, Z. B., III 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

NICHOLAS, EDMUND M. 29 ACT U
401 PEACHTREE ST., N.E., ATLANTA 30308

NICHOLS, JOSEPH J. 29 ACT PR
490 PEACHTREE ST., N. E., ATLANTA 30308

NICKERSON, JOHN F. 29 ACT PATH
35 LINDEN AVE., N.E., ATLANTA 30308

NICOLSON, WM. P., III 29 ACT U
35 COLLIER RD., N.W., ATLANTA 30309

NILES, GEORGE A., JR. 29 ACT OBG
1938 PEACHTREE RD., N.W., ATLANTA 30309

NINCIC, ALEXANDER 29 ACT U
490 PEACHTREE ST., N.E., ATLANTA 30308

NINO, HOMERO F. 29 S R
P. O. BOX 33325, DECATUR 30033

NIPPERT, PHILIP H. 29 ACT D
478 PEACHTREE ST., N.E., ATLANTA 30308

NOLAN, THOMAS R. 29 ACT SL
2788 BAYARD ST., EAST POINT 30344

NORTH, ALVIN W. 29 ACT OPH
575 W. PEACHTREE ST., N. E., ATLANTA 30308

NORWOOD, SAM W. 29 ACT OBG
564 LEE ST., S. W., ATLANTA 30310

NORWOOD, WM. F. 29 ACT PD
3158 MAPLE DR., N.E., ATLANTA 30305

NUNEZ, WILLIAM D. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344

NUTTER, DONALD O. 29 A I
69 BUTLER ST., S.E., ATLANTA 30303

OBRIEN, DAVID P. 29 ACT U
1365 CLIFTON RD., N.E., ATLANTA 30322

OBRIEN, MARK S. 29 ACT NS
1365 CLIFTON RD., N.E., ATLANTA 30322

OLANSKY, MARIAN F. 29 ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322

OLANSKY, SIDNEY 29 ACT D
EMORY UNIV. CLINIC, ATLANTA 30322

ONEAL, BUFORD L. 29 ACT OALR
478 PEACHTREE ST., N. E., ATLANTA 30308

ORFUSS, CARL J. 29 ACT N
340 BOULEVARD, N.E., ATLANTA 30312

ORTEGA, HERNANDO JOSE 29 ACT SU
2958 RAINBOW DR., DECATUR 30034

OSBORNE, ELTON S., JR. 29 ACT I
47 TRINITY AVE., S. W., ATLANTA 30334

OTIS, JOHN B. 29 ACT PATH
340 BOULEVARD, N.E., ATLANTA 30312

OVERTON, JOHN W., JR. 29 ACT EM
1170 CLEVELAND AVE., EAST POINT 30344

PALAY, BERNARD H. 29 ACT I
1175 PEACHTREE ST., N. E., ATLANTA 30309

PALMER, E. CAPERS, JR. 29 ACT PATH
35 LINDEN AVE., N.E., ATLANTA 30308

PALMER, JAMES D. 29 ACT I
970 HUNTER STREET, S.W., ATLANTA 30314

PARUNGAO, ROMULO L. 29 ACT SL
1235 SALEN GATEWAY, CONYERS 30207

PARNELL, R. PARKS, JR. 29 ACT FP
OAKDALE CLINIC, SMYRNA 30080

PARUNGAO, R. L. 29 ACT SL
1235 SALEN GATEWAY, CONYERS 30207

PATTERSON, SCDTT 29 ACT P
811 JUNIPER ST., N.E., ATLANTA 30308

PATTERSON, JDS. H. 29 ACT PD
1405 CLIFTDN RD., N.E., ATLANTA 30333

PAULK, E. ALAN, JR. 29 ACT I
6 LAVISTA PERIMETER DFC. PK., TUCKER 30084

PAJLLIN, WM. L., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

PAYNE, NETTLETON S. 29 ACT N
1365 CLIFTON RD., NE, ATLANTA 30322

PAYNE, PETER M. 29 ACT O8G
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

PEACDCK, LAMAR 8. 29 ACT I
478 PEACHTREE ST., N.E., ATLANTA 30308

PEACOCKE, IVAN L. 29 ACT PATH
35 LINDEN AVE., N. E., ATLANTA 30322

PEARCE, T. ELDER, JR. 29 ACT SU
960 JOHNSDN FERRY RD., N.E., ATLANTA 30342

PEAVY, PATRICK W. 29 DE2 FP
4853 RIVER 8ASIN DR.,JACKSONVILLE,FL 32207

PEEK, STANLEY L., JR. 29 ACT SU
1935 HOWELL MILL RD., N.W., ATLANTA 30318

PENDERGRAST, WM. J. 29 ACT SU
478 PEACHTREE ST., N.E. ATLANTA 30308

PENNINGTON, E. EARL 29 ACT SU
960 JOHNSDN FERRY RD., N.E., ATLANTA 30342

PENTECDST, MARK P. 29 ACT D8G
35 CDLLIER RD., N.W., ATLANTA 30309

PERDUE, GARLAND O., JR. 29 ACT SU
EMDRY UNIVERSITY CLINIC, ATLANTA 30322

PEREZ, A. R. 29 ACT SU
1311 CLEVELANC AVE., EAST PDINT 30344

PERKINS, J. MDRRIS 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

PERKINSON, NEIL G. 29 ACT SU
384 PEACHTREE ST., N. E., ATLANTA 30308

PER-LEE, JOHN H. 29 ACT ALR
EMORY UNIV. CLINIC, ATLANTA 30322

PERLING, DAVIS S. 29 ACT I
4536 CHAM8LEE-DUNWODDY RD., CHAM8LEE 30341

PERRY, SAMUEL W. 29 DE5 PD
5675 PTREE-DNWDY RD., STE 502, ATL 30342

PĖSZCZYNSKI, MIECZYSLAW 29 ACT PM
80 8UTLER ST., S. E., ATLANTA 30303

PETERS, MARGARET P. 29 S ANES
1670 CLAIRMDNT RD., N. E., ATLANTA 30329

PETRIE, LESTER M. 29 DE1 PH
304 WILTON DR., DECATUR 30030

PHILLIPS, CHARLES D. 29 ACT DR
607 HDLCDM8 8RIDGE RD., RDSWELL 30075

PHILLIPS, THDMAS W. 29 ACT R
25 PRESCDTT ST., ATLANTA 30308

PHRYDAS, IRENE A. 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

PIERDTTI, JULIUS V. 29 DE1 FP
2407 E. CLU8 DR., N.E., ATLANTA 30319

PINTO, AL8ERT P. 29 ACT OBG
4637 ELLIS8URG DR.,'N.E., ATLANTA 30341

PIRKLE, CECIL H. 29 ACT SU
1311 CLEVELAND AVE., EAST POINT 30344

PITTMAN, FRANK S., III 29 ACT P
960 JDHNSON FERRY RD., N.E., ATLANTA 30342

PLAUTH, WILLIAM H., JR. 29 ACT PDC
1365 CLIFTDN RD., N.E., ATLANTA 30322

POLIAKOFF, SAMUEL R. 29 ACT OBG
3312 PIEDMDNT RD., N.E., ATLANTA 30305

POLITSDS, MICHAEL J. 29 ACT SU
35 LINDEN AVE., N.E., ATLANTA 30308

POLLARD, ZANE F. 29 ACT OPH
575 W. PTREE ST., NE, ATLANTA 30308

PONCE DE LEDN, A. I. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

POOLE, ROBERT NEIL 29 ACT PD
5675 PTREE-DUNWODDY RD. N.E. ATLANTA 30342

PORTER, MAC W. 29 ACT FP
MEDICAL CENTER, COLUMBUS 31902

PORTH, EDNA S. 29 ACT FP
3130 MAPLE DR., N. E., ATLANTA 30305

POU, LEO H., JR. 29 ACT ANES
2760 FELTDN DR., EAST PDINT 30344

POUND, EDWIN C., JR. 29 ACT PL
35 COLLIER RD., N.W., ATLANTA 30309

PREEDY, JDHN R. K. 29 ACT I
69 8UTLER ST., S.E., ATLANTA 30303

PRICE, NORMA A. 29 ACT I
960 JDHNSDN FERRY RD., N.E., ATLANTA 30342

PRUCE, MARTA 29 ACT P
10 CARLTDN DR., N.W., ATLANTA 30342

PUGH, JAMES W. 29 ACT FP
461 KING ARNDLD ST., HAPEVILLE 30354

QUARTERMAN, KEITH A. JR. 29 ACT SU
960 JDHNSON FERRY RD., N.E., ATLANTA 30342

QUINN, FRANCIS 8., JR. 29 ACT DALR
144 PONCE DE LEON AVE.,N.E., ATLANTA 30308

QUINONES, PEDRO P. 29 A
99 8UTLER ST., S.E., ATLANTA 30303

RAIFDRD, MDRGAN 8. 29 ACT DPH
705 JUNIPER ST., N. E., ATLANTA 30308

RAMDS, HAROLD S. 29 ACT I
35 LINDEN AVE., N.E., ATLANTA 30308

RAND, EDGAR D. 29 ACT SU
35 COLLIER RD., N.W., ATLANTA 30309

RANKIN, JOSEPH L. 29 ACT D
384 PEACHTREE ST., N. E., ATLANTA 30308

RANKINE, C. A. N. 29 ACT FP
1224 FERNWDDD CIR., ATLANTA 30319

RASCDE, E. MARSTON 29 ACT P
3400 PEACHTREE RD., N.E., ATLANTA 30326

RASMUSSEN, E. P. 29 ACT R
1968 PEACHTREE RD., N. W., ATLANTA 30309

RAYEL, PETER A. 29 ACT G
6500 VERNDN WDODS DR., N.E., ATLANTA 30328

RAYLE, AL8ERT A., JR. 29 ACT R
490 PEACHTREE ST., N. E., ATLANTA 30308

READ, 8EN S. 29 ACT G
340 8LVD., N. E., ATLANTA 30312

READ, JDS. C. 29 DE5 SU
3970 VERMONT RD., N.E., ATLANTA 30319

REDD, 8RYAN L., JR. 29 ACT R
401 PEACHTREE ST., N.E., ATLANTA 30308

REDD, STEPHEN C. 29 DE5 PD
2760 FELTDN DR., EAST POINT 30344

REDD, STEPHEN S. 29 ACT PD
2760 FELTON DR., EAST POINT 30344

REED, EDGAR A. 29 S I
1670 CLAIRMDNT RD., DECATUR 30033

REEVES, MARTIN M. 29 ACT ANES
485 N. HAR8DR DR., ATLANTA 30328

REEVES, W. HARRISON 29 ACT I
478 PEACHTREE STREET, N. E., ATLANTA 30308

REHERT, GERALD M. 29 ACT O8G
490 PTREE ST., STE 132-B, ATLANTA 30309

REICH, GEORGE A. 29 S PH
PEACHTREE 7TH BLDG., ATLANTA 30323

REID, WM. A. 29 ACT SU
340 8ULEVARD, NE, ATLANTA 30312

REISH, MARTIN L. 29 ACT PD
4536 CHAMBLEE-DUNWODDY RD., CHAM8LEE 30341

REITT, J. PETER 29 ACT NS
100 CDLDNY SQUARE, ATLANTA 30361

REYNAUD, L. F. 29 ACT PD
1278 GDRDON ST. S. W., ATLANTA 30310

REYNAUD, VIRGINIA G. 29 ACT PD
1278 GDRDDN ST. S. W., ATLANTA 30310

REYNOLDS, J. S. 29 ACT FP
553 MO8ILE AVE., S.W., ATLANTA 30315

RICE, KEITH C. 29 DE5 SU
RT. 1, CLAYTDN 30525

RICHARDSON, A. C., JR. 29 ACT D8G
710 PEACHTREE ST., N. E., ATLANTA 30308

RICHARDSON, HDWARD D. 29 ACT NS
340 8ULEVARD, N.E., ATLANTA 30312

RICHARDSON, STERLING H. 29 ACT SU
478 PEACHTREE ST., N. E., ATLANTA 30308

RICHMAN, GARY D. 29 ACT DPH
3316 PIEDMONT RD., N. E., ATLANTA 30305

RICHMOND, LEA 29 ACT SU
6500 VERNDN WDODS DR., ATLANTA 30328

RICKS, HENRY C., JR. 29 ACT P
415 E. PACES FERRY RD.,N.E., ATLANTA 30305

RICKS, RD8ERT L. 29 ACT D8G
565 FAIR ST., S.W., ATLANTA 30314

RIDLEY, HARRY W. 29 DE5 FP
SEA ISLAND 31561

RIDLEY, JDHN H. 29 ACT G
35 CDLLIER RD., N.W., ATLANTA 30309

RIESER, CHARLES 29 DE5 OPH
3777 PACES FERRY RD., N. W., ATLANTA 30327

RIESER, JOHN C. 29 ACT OPH
1365 CLIFTDN RD., N.E., ATLANTA 30322

RIST, KARL H. 29 ACT R
2440 EDGEWATER DR. S. W., ATLANTA 30311

RITCHEY, STERLING J. 29 ACT DR
EMORY UNIV. CLINIC, ATLANTA 30322

RIVERS, SHIRLEY L. 29 A I
1925 MONRDE DR., N.E., ATLANTA 30324

RIVKIN, LAWRENCE M. 29 ACT TS
1220 PACES FOREST DR., N. W., ATL 30327

ROACH, GEDRGE S., JR. 29 ACT ALR
144 PONCE DE LEON AVE. N.E., ATLANTA 30308

RD8ERTS, JDHN MANLEY 29 ACT DR
1938 PEACHTREE RD., N.W., ATLANTA 30309

RO8INSON, AL8ERT H. 29 A PH
3060 PHARR CDURT, N.W., ATLANTA 30305

RO8INSDN, PAUL H. 29 ACT C
1365 CLIFTON RD., N. E., ATLANTA 30322

RO8INSDN, RALPH L. 29 ACT PD
3158 MAPLE DR., N.E., ATLANTA 30305

RO8ITSCHER, JONAS 29 ACT P
EMORY UNIV. LAW SCHDOL, ATLANTA 30322

RODRIGUEZ, A. P. 29 ACT U
340 8OULEVARO, N.E., ATLANTA 30312

RODRIGUEZ, FERNANDO 29 S I
P. O. 8DX 33115, N. DECATUR 30033

RODRIQUEZ, J. I. 29 ACT I
3307 PRINCE GEDRGE ST., EAST PDINT 30344

ROGERS, CHARLES G. 29 ACT D8G
340 8DULEVARD, N.E., ATLANTA 30312

RDGERS, HARRISON L., JR. 29 ACT SU
1938 P8TREE RD., N. W., STE 601, ATL 30309

RDGERS, J. HARRY 29 DE5 SU
490 PEACHTREE ST., N.E., ATLANTA 30308

RODKER, DONALD W. 29 ACT OALR
1365 CLIFTON RD., N. E., ATLANTA 30322

ROSEN8AUM, 8ARRY J. 29 ACT NE
1365 CLIFTDN RD, NE, ATLANTA 30322

ROSSI, AL8ERTO E. 29 ACT D8G
2744 FELTDN DR., EAST PDINT 30344

ROTHEN8ERG, MARVIN 8. 29 ACT DR
6500 VERNDN WDODS DR., N. E., ATL. 30328

ROTTERSMAN, WILLIAM 29 ACT P
3280 HOWELL MILL RD. N. W., ATLANTA 30327

ROUGHTON, RALPH E., JR. 29 ACT P
1175 PEACHTREE ST., N.E., ATLANTA 30309

ROUTON, JAMES L. 29 ACT ANES
705 JUNIPER ST., N. E., ATLANTA 30308

ROWE, THDMAS S. 29 ACT DPH
478 P8TREE ST., NE, STE 820-A, ATL. 30308

RUBENSTEIN, ARNOLD 8. 29 ACT U
2788 BAYARD ST., EAST POINT 30344

RUDDER, FRED F. 29 DE5 SU
465 HILLSIDE DR., N. W., ATLANTA 30342

RUDER, ERNST M. 29 ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

RUSCA, JDHN A. 29 ACT PL
1311 CLEVELANC AVE. N. E., ATLANTA 30344

RUSHIN, C. E. 29 DE5 SU
478 PEACHTREE STREET, NE, ATLANTA 30308

RUSSELL, DAVID A. 29 ACT FP
340 BOULEVARD, N.E., ATLANTA 30312

RUSSELL, E. K. 29 ACT I
573 W. PTREE ST., N.E., ATLANTA 30308

RUSSELL, R. JAMES 29 ACT PL
3250 HOWELL MILL RD., N.W., ATLANTA 30327

RUTLEDGE, BEN A. 29 DE1 OR
2348 ECHO CLIFF CT., N. E., ATLANTA 30345

SAFFAN, B. D. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308

SAFWAT, MOHAMED 29 A SU
1501 CLAIRMONT RD., DECATUR 30030

SAIN, ROBERT L. 29 A SU
US NAVAL HOSP., CHERRY POINT, NC 28533

ST. LOUIS, JOSEPH A., JR. 29 ACT OPH
275 CARPENTER DR., ATLANTA 30328

SAKER, A. F. 29 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30341

SALAM, ATEF A. 29 ACT SU
69 BUTLER ST.,S.E., ATL. 30303

SALE, WALTER T. 29 ACT R
35 COLLIER RD., N.W., ATLANTA 30309

SALTER, PAUL P. III 29 A SU
3131 LAVENTURE DR., CHAMBLEE 30341

SAMMONS, EDWARD E. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322

SANCHEZ-MORENO, H. L. 29 ACT OBG
2739 FELTON DR., EAST POINT 30344

SANDERS, C. VERNON 29 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

SANDERS, STEVEN L. 29 ACT SU
490 PEACHTREE ST., N. E., ATLANTA 30308

SANDISON, J. CALVIN 29 DE5 OR
P. O. BOX 56422, ATLANTA 30343

SARDIE, SOLOMON Y. 29 ACT SU
2788 BAYARD ST., EAST POINT 30344

SARGENT, CARLTON W. 29 A PH
618 PONCE DE LEON AVE., NE, ATLANTA 30308

SATCHER, MILTON B., JR. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344

SCHATTEN, WM. E. 29 ACT PL
1938 PEACHTREE RD., N. W., ATLANTA 30309

SCHELLACK, J. K. 29 ACT SU
490 PEACHTREE ST., N.E., ATLANTA 30308

SCHERMERHORN, THOMAS J. 29 ACT OPH
705 JUNIPER ST., N. E., ATLANTA 30308

SCHLANT, ROBERT C. 29 ACT I
69 BUTLER ST., S. E., ATLANTA 30303

SCHLOSSBERG, MICHAEL 29 ACT OBG
2788 BAYARD ST., EAST POINT 30344

SCHMITT, ELBERT W., JR. 29 ACT OR
1365 CLIFTON RD., N. E., ATLANTA 30322

SCHOENBUCHER, ALBERT K. 29 A DBG
47 TRINITY AVE., S. W., ATLANTA 30334

SCHRODER, J. SPALDING 29 ACT I
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322

SCHWARTZ, JAMES F. 29 ACT PD
69 BUTLER ST., S.E., ATLANTA 30303

SCHWARTZ, SANFORD H. 29 ACT I
4536 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

SCHWARZMANN, STEPHEN W. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

SCOTT, LEIGH R. 29 ACT I
3312 PIEDMONT RD., N. E., ATLANTA 30305

SCOTT, THOMAS P., JR. 29 ACT PD
1311 CLEVELAND AVE., EAST POINT 30344

SEALEY, ROMERO M. 29 ACT DBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SEARS, ROBERT A. 29 ACT NS
1175 PEACHTREE ST., N. E., ATLANTA 30361

SEAVEY, PAUL W. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

SELLERS, T. F. 29 DE5
STATE DEPT. OF PUB. HEALTH, ATLANTA 30334

SELVEY, HENRY A. 29 ACT P
6363 ROSWELL RD., N.E., ATLANTA 30328

SERBES, YILMAZ A. 29 ACT OR
5583 GORDON RD., MABLETON 30059

SESSIONS, HOWARD K. 29 A PH
P. O. BOX 781, SUMNER 31789

SHACKELFORD, HUGH W. 29 ACT R
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SHAMA, ZOUTHEIR A. 29 ACT SL
2931 APPLING DR., CHAMBLEE 30341

SHANKS, JAMES Z. 29 ACT I
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

SHANTHA, TOTADA R. 29 ACT ANES
384 PEACHTREE ST., N.E., ATLANTA 30308

SHEA, P. C., JR. 29 ACT SU
25 PRESCOTT ST.,N.E., ATLANTA 30308

SHEAHAN, ROBERT C. 29 A ADM
1800 PEACHTREE ST., N.E., ATLANTA 30309

SHEHEE, WALTER H. 29 ACT P
1338 CLEVELAND AVE., EAST POINT 30344

SHEPARD, DUNCAN 29 ACT SL
3312 PIEDMONT RD., N.E., ATLANTA 30305

SHESSEL, HERBERT L. 29 ACT OBG
340 BOULEVARD, NE, ATLANTA 30312

SHINALL, ROBERT P. 29 DE1 FP
927 ARTWOOD RD., N. E., ATLANTA 30307

SHMERLING, SANFORD A. 29 ACT I
3316 PIEDMONT RD., N. E., ATLANTA 30305

SHORTER, HENRY F., JR. 29 ACT FP
960 HUNTER ST., S.W., ATLANTA 30314

SHUFORD, WADE H. 29 A R
80 BUTLER ST., S. E., ATLANTA 30303

SHULER, ROBERT K. 29 ACT PD
3158 MAPLE DR., N.E., ATLANTA 30305

SHULMAN, MICHAEL G. 29 ACT I
3200 HOWELL MILL RD., N.W. ATLANTA 30327

SIEGAL, JEROME H. 29 ACT I
103B W. PEACHTREE ST., NW, ATL 30309

SIEVERT, ALAN J. 29 ACT PD
1100 CLEVELAND AVE., EAST POINT 30344

SIGMAN, CHENEY C. 29 ACT AL
3393 PEACHTREE RD., N.E., ATLANTA 30326

SILLER, EVERARD J. 29 ACT N
MONASTERY OF THE HOLY SPIRIT, CONYER 30207

SILVERMAN, BARRY O. 29 A C
1000 JOHNSON FRY. RD., NE, ATLANTA 30342

SILVERSTEIN, CHARLES M. 29 ACT R
3312 PIEDMONT RD., N. E., ATLANTA 30305

SIMMONS, WILLIAM C. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

SIMONE, GREGORY L. 29 A
80 BUTLER ST., SE, ATLANTA 30303

SIMONTON, KINSEY M. 29 ACT OTO
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SIMS, STEWART EUGENE 29 ACT SU
AT&T-100 EDGEWOOD AVE, RM. 1605, ATL 30302

SKANDALAKIS, JOHN E. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

SKARDASIS, GEORGE M. 29 ACT VS
25 PRESCOTT ST., N.E., ATLANTA 30308

SKELTON, W. DOUGLAS 29 ACT P
47 TRINITY AVE., S.W., ATLANTA 30334

SKOBBA, JOSEPH S. 29 A P
2386 DELLWOOD DR., N.W., ATLANTA 30305

SKORAPA, MARY Z. 29 ACT PM
80 BUTLER ST., S. E., ATLANTA 30303

SKORAPA, VICTOR, JR. 29 S R
1670 CLAIRMONT RD., N. E., ATLANTA 30329

SLADE, JOHN DER. 29 ACT I
768 JUNIPER ST., N. E., ATLANTA 30308

SLOAN, W. P. 29 DE5 I
340 BLVD., N. E., ATLANTA 30312

SLOAN, W. P., JR. 29 ACT I
340 BLVD. N. E., ATLANTA 30312

SLUTSKY, MORTON 29 ACT PL
275 CARPENTER DR., N. W., ATLANTA 30328

SMILEY, DAVID T. 29 ACT ALR
3316 PIEDMONT RD., N.E., ATLANTA 30305

SMITH, ARTHUR A. 29 ACT OBG
401 PEACHTREE ST., N.E., ATLANTA 30308

SMITH, CARTER 29 DE5 I
35 COLLIER RD., N. W., ATLANTA 30309

SMITH, CARTER, JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

SMITH, CHAS. W. 29 ACT OBG
57 SIXTH ST., N. E., ATLANTA 30308

SMITH, E. G., JR. 29 ACT R
35 LINDEN AVE., N.E., ATLANTA 30308

SMITH, JOEL P., JR. 29 ACT DALR
573 W. PEACHTREE ST., N. E., ATLANTA 30308

SMITH, RICHARD A. 29 ACT NS
35 COLLIER RD., N.W., ATLANTA 30309

SMITH, RICHARD B. 29 ACT PD
5675 PTREE-DUNWOODY RD., N.E., ATL. 30342

SMITH, ROBERT B., III 29 ACT SU
1365 CLIFTON RD., N.E., ATLANTA 30322

SMITH, ROBERT W. 29 ACT I
478 PEACHTREE ST.,N.E., ATLANTA 30308

SMITH, WM. A. 29 DE5 N
35 COLLIER RD., N.W., ATLANTA 30309

SMITH, WILLIAM A., JR. 29 ACT OPH
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

SMITH, WILLIAM S. 29 ACT OTO
401 PEACHTREE ST., N.E., ATLANTA 30308

SNITZER, JOSEPH A., III 29 ACT PO
3162 PIEDMONT RD., N. E., ATLANTA 30305

SODER, PARRY O. 29 ACT R
265 IVY ST., N. E., ATLANTA 30303

SONES, PETER J. 29 ACT R
1365 CLIFTON RD., N. E., ATLANTA 30322

SORACCO, GERARDO J. 29 ACT TS
1311 CLEVELAND AVE., EAST POINT 30344

SORIANO, MARIA J. R. 29 ACT PD
35 COLLIER RD., N.W., ATLANTA 30309

SORSDAHL, OLIVER A. 29 ACT R
300 BOULEVARD, NE, ATLANTA 30312

SOWELL, DAVID S. 29 ACT FP
2797 CAMPBELLTON RD., ATLANTA 30311

SPANIER, JACOB A. 29 ACT OBG
340 BOULEVARD, N.E., ATLANTA 30312

SPEARMAN, WILLIAM B. 29 ACT I
1201 PEACHTREE ST. ATLANTA 30361

SPENCER, WM. C., III 29 ACT R
35 LINDEN AVE., ATLANTA 30308

SPIER, EUGENE 29 ACT ANES
4195 GLEN DEVON DR., N.W., ATLANTA 30327

STAATS, ETHAN F. 29 ACT OALR
35 COLLIER RD., N.W., ATLANTA 30309

STACY, L. DAVID 29 ACT PATH
1000 JOHNSON FERRY RD., N.E., ATL. 30342

STAPLETON, SIDNEY L., JR. 29 ACT VS
735 PIEDMONT AVE., N.E., ATLANTA 30308

STATON, TED L. 29 ACT L
340 BOULEVARD, N.E., ATLANTA 30312

STEADMAN, HENRY E. 29 ACT SL
340 BOULEVARD, N. E., ATLANTA 30312

STEIN, IGNATIUS J. 29 ACT SU
2391 SEWELL RD., S. W., ATLANTA 30311

STEINHAUS, JOHN E. 29 ACT ANES
1365 CLIFTON RD., N.E., ATLANTA 30322

STEPHENSON, ROBERT H. 29 ACT SU
3250 HOWELL MILL RD., N.W., ATLANTA 30327

STEWART, CALVIN B. 29 DE5 SU
478 PEACHTREE ST., N. E., ATLANTA 30308

STIVERS, ROBERT R. 29 ACT PATH
50 CDCA CDLA PLACE, SE, ATLANTA 30303

STOKES, J. JACK 29 ACT OPH
478 PEACHTREE ST., N. E., ATLANTA 30308

STONE, ALBERT LAWRENCE 29 ACT PD
1035 MAIN STREET, FOREST PARK 30050

STONE, CHARLES F., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

STONE, H. HARLAN 29 ACT SU
1365 CLIFTON RD., N. E., ATLANTA 30322

STONE, WILLIAM D. 29 ACT
573 W. PEACHTREE ST., N.E., ATLANTA 30303

STONER, CYRUS H. 29 OE5 OPH
340 BOULEVARD, N.E., ATLANTA 30312

STRICKLER, C. W., JR. 29 DE1 I
215 TOWNSEND PL., N.W., ATLANTA 30327

STROUP, DAVID G. 29 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30344

STUART, CARLOS A. 29 ACT I
1201 PEACHTREE ST., N.E., ATLANTA 30361

STUART, WILLIAM H. 29 ACT I
3312 PIEDMONT RD., N.E., ATLANTA 30305

STURM, HIRAM MAXWELL 29 ACT O
401 PEACHTREE ST., N.E., ATLANTA 30308

SUIT, JAMES I. 29 I&R OPH
80 BUTLER ST., S.E., ATLANTA 30303

SULLIVAN, CARY E. 29 ACT PD
2555 CUMBERLAND PKWY, ATLANTA 30339

SUNG, YUNG-FONG 29 ACT ANES
EMORY UNIV. HOSP., DEPT. ANES., ATL 30322

SWANN, JULIAN W. 29 ACT D
490 PEACHTREE ST., N.E., ATLANTA 30308

SWANSON, HOMER 29 ACT NS
1938 PEACHTREE RD., N. W., ATLANTA 30309

SWISTERSKI, K. PETER 29 ACT ANES
20 LINDEN AVE., N.E., ATLANTA 30308

SYMBAS, PETER 29 ACT TS
69 BUTLER ST., S. E., ATLANTA 30303

TAIT, C. DOWNING, JR. 29 ACT P
820 DOUGLAS RD., N.E., ATLANTA 30342

TANNER, JAMES C., JR. 29 ACT SL
25 PRESCOTT ST., N.E., ATLANTA 30308

TARANTO, MORRIS B. 29 ACT FP
727 W. PEACHTREE STREET, NE, ATLANTA 30308

TARCAN, YAVUZ A. 29 A I
80 BUTLER ST., S.E., ATLANTA 30303

TAUBER, CHARLES P. 29 ACT P
415 E.PACES FERRY RD., N.E., ATLANTA 30305

TAYLOR, DAVID M. 29 ACT I
340 BOULEVARD, N. E., ATLANTA 30312

TAYLOR, TERRY W. 29 ACT OPH
960 JOHNSON FERRY ROAD, N.E., ATL 30342

TAYLOR, WILLIAM J. 29 ACT FP
2049 PERKERSON RD., S. W., ATLANTA 30310

TEKIN, MAHIR 29 ACT ANES
3240 JETT FERRY CT., N.E., DUNWOODY 30338

TEMPLES, POWELL M., JR. 29 DE4 P
209 EERIE AVE, DECATUR 30033

TEPLIS, PAUL 29 ACT I
3250 HOWELL MILL RD., N.W., ATLANTA 30327

TERRY, JULES S. 29 A OBG
47 TRINITY AVE., ATLANTA 30334

THEBAUT, BEN R. 29 ACT SL
1293 PEACHTREE ST., N.E., ATLANTA 30309

THOMAS, KENNETH E. 29 ACT SL
1938 PEACHTREE RD., N. W., ATLANTA 30309

THOMASON, W. L. 29 DE5 SL
1272 BREEZY LN., N.E., ATLANTA 30329

THOMPSON, D. O. 29 DE5 FP
478 PEACHTREE ST., N.E., ATLANTA 30308

THOMPSON, HUGH S., JR. 29 ACT OR
1203 CLEVELAND AVE., EAST POINT 30344

THOMPSON, JOHN D. 29 ACT OBG
69 BUTLER ST., S.E. ATLANTA 30303

THOMPSON, JOHN W. 29 DE1 PD
3814 VERMONT RD., N.E., ATLANTA 30319

THOMPSON, ROBERT F. 29 ACT OALR
P.O. BOX 368, NEWNAN 30263

THOMPSON, WILLIAM R. 29 ACT OBG
1691 CANDLER ROAD, DECATUR 30032

THORNTON, NATHANIEL A. 29 ACT I
1201 PEACHTREE ST., N.E., ATLANTA 30361

THRASHER, BARRIE H., JR. 29 ACT OPH
3280 HOWELL MILL RD.,NW,STE 207, ATL 30327

THRONE, MARTIN L. 29 ACT I
3648 CHAMBLEE-TUCKER RD., CHAMBLEE 30340

THWAITE, WALTER G. 29 A OBG
69 BUTLER ST., S.E., ATLANTA 30303

TIDMORE, THOMAS L., JR. 29 ACT ANES
1405 CLIFTON RD., N.E., ATLANTA 30322

TIMBERLAKE, G. B. 29 ACT SL
133 CARNEGIE WAY, N.W., ATLANTA 30303

TIMBERLAKE, LLOYD F. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

TINDALL, HARRY C. 29 ACT DPH
1938 PEACHTREE RD., N.W., ATLANTA 30309

TODD, CHARLES E., JR. 29 ACT SU
35 COLLIER RD., N.W., ATLANTA 30309

TOMAS, TEOFILO 29 ACT OPH
490 PEACHTREE ST., N.E., ATLANTA 30308

TODLE, WM. NISBET 29 ACT L
6500 VERNON WOODS RD., N.E., ATLANTA 30328

TOPOROFF, STUART J. 29 ACT I
265 IVY ST., N.E., ATLANTA 30303

TORNOW, ABRAHAM M. 29 S GE
1670 CLAIRMONT RD., N. E., ATLANTA 30329

TUCKER, R. P. 29 ACT SL
1603 WARE AVE., EAST POINT 30344

TURK, L. NEWTON, III 29 ACT TS
35 COLLIER RD., N.W., ATLANTA 30309

TURNER, AUGUST B. 29 ACT SL
384 PEACHTREE ST., N.E., ATLANTA 30308

TURNER, CORBETT H. 29 ACT P
EMORY UNIV. CLINIC, ATLANTA 30322

TURNER, JOHN S., JR. 29 ACT DALR
1365 CLIFTON RD. N. E., ATLANTA 30322

TURNER, JOHN W. 29 DE5 SL
756 CYPRESS ST., N. E., ATLANTA 30308

TURRENTINE, PAUL E. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

TUTSCH, WILBERT R. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344

TUTTLE, ELBERT P., JR. 29 A I
69 BUTLER ST., S. E., ATLANTA 30303

TYLER, RICHARD M. 29 ACT OR
2351 BOLTON RD., N.E., ATLANTA 30318

UFEMA, JOHN W. 29 DE2 R
2666 PANGBORN RD., DECATUR 30033

UHL, LAWRENCE W. 29 ACT PD
6043 NAVAHO TR., MORROW 30260

ULLMAN, KARL H. 29 ACT I
1311 CLEVELAND AVE., EAST POINT 30344

ULLOA, A. N. 29 ACT I
2756 FELTON DR., EAST POINT 30344

UNDERWOOD, FRANK O. 29 ACT R
1968 PEACHTREE RD., N.W., ATLANTA 30309

UPCHURCH, W. E. 29 DE5 U
98 CURRIER ST., N. E., ATLANTA 30308

UPSHAW, CHARLES B., JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

UPSON, E. T. 29 S RET
RT. 7, BOX 241, CUMMING 30130

VAN BUREN, E. 29 DE5 I
768 JUNIPER ST., N. E., ATLANTA 30308

VAN BUREN, JAMES K. 29 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

VAN DE WETERING, R. J. 29 ACT P
6500 VERNON WOODS DR., N.E., ATLANTA 30328

VARNER, JOHN B. 29 ACT OBG
490 PEACHTREE ST., N.E., ATLANTA 30308

VASCONEZ, LUIS O. 29 ACT PL
1365 CLIFTON RD., ATLANTA 30322

VEATCH, J. W., JR. 29 ACT SL
25 PRESCOTT ST., N.E., ATLANTA 30308

VELKOFF, ABRAHAM S. 29 ACT OBG
1175 PEACHTREE ST., N. E., ATLANTA 30309

VENABLE, JOHN H. 29 A PH
2300 MANCHESTER RD., COLUMBUS 31904

VERLEY, KARL W. 29 ACT OBG
2945 STONE HOGAN RD., S.W., ATLANTA 30331

VISINTINE, AAROLYN M. 29 A PD
69 BUTLER ST., S.E., ATLANTA 30303

VITNER, SAUL 29 ACT OBG
275 CARPENTER DR., N.E., ATLANTA 30328

VOHMAN, MANN CARIUS 29 ACT PATH
1968 PEACHTREE RD., N.W., ATLANTA 30309

VOLJAVEC, BOZIDAR F. 29 ACT FP
1311 CLEVELAND AVE., EAST POINT 30344

VON HAAM, EMMERICH, JR. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344

WADSWORTH, GERALD E. 29 ACT OPH
478 PEACHTREE ST., N.E., ATLANTA 30308

WAGGONER, DAVID C. 29 ACT P
1970 CLIFF VALLEY WAY, NE, ATLANTA 30329

WAITS, EDWARD JONES 29 ACT SL
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

WALKER, HENRY K. 29 A I
80 BUTLER ST., S.E., ATLANTA 30303

WALKER, JOHN R. 29 DE5 SU
922 W. PTREE ST., ATLANTA 30309

WALKER, LEO L., JR. 29 A I
2417 BERMUDA HILLS RD., COLUMBIA S.C 29204

WALTER, JONNE B. 29 A I
300 BOULEVARD, N.E., ATLANTA 30312

WALTON, KENNETH N. 29 ACT L
1365 CLIFTON RD., N.E., ATLANTA 30322

WARD, JOHN ALBIN 29 S
1670 CLAIRMONT RD., N. E., ATLANTA 30329

WARD, M. TERRY 29 ACT ER
1405 SHADOWOOD PKWY, NW., ATLANTA 30339

WARD, RICHARD S. 29 ACT P
EMORY UNIV., ATLANTA 30322

WARD, WM. C. 29 ACT SL
2292 FAIRBURN RD., S. W., ATLANTA 30331

WARKENTIN, JOHN 29 ACT P
2905 PEACHTREE RD., N.E., ATLANTA 30305

WARNER, CLINTON E. 29 ACT SL
319 W. LAKE AVE., N.W., ATLANTA 30318

WARNER, WM., PHILIP, JR. 29 ACT OR
35 COLLIER RD., N.W., ATLANTA 30309

WARREN, CECIL D. 29 ACT
1143 BANBURY CRDSS, AVONDALE ESTATES 30002

WARREN, HOWELL R. 29 ACT P
1970 CLIFF VALLEY WAY, NE, ATLANTA 30329

WARREN, W. C., JR. 29 DE5 ALR
490 PEACHTREE ST., N. E., ATLANTA 30308

WARREN, WALTER D. 29 ACT SU
1364 CLIFTON RD., N.E., ATLANTA 30322

WASHBURN, LAWRENCE, JR. 29 ACT P
3400 PEACHTREE RD., N. E., ATLANTA 30326

WASSERMAN, STANLEY B. 29 ACT PD
1175 JOHNSON RD., N. W., ATLANTA 30318

WATERS, JAMES L., JR. 29 ACT OBG
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

WATERS, WM. C., III 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WATKINS, JAMES W., JR. 29 ACT SL
623 PARK LN., DECATUR 30033

WATSON, DAVID T. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WATSON, FRANCIS M., JR. 29 DE2 OR
20 W. 64TH ST., 18-P, NY NY 10023

WATTERS, JULIAN Q. 29 ACT PD
5675 PTREE-DUNWOODY RD. N.E., ATL 30342

WEAVER, WILLIAM T. 29 ACT TS
340 BOULEVARD, N. E., ATLANTA 30312

WEBSTER, ROBERT M. 29 ACT FP
2415 FAIRBURN RD., S.W., ATLANTA 30331

WEENS, H. S. 29 ACT R
80 BUTLER ST., S. E., ATLANTA 30303

WEINBERG, SEYMOUR PAUL 29 ACT OBG
384 PEACHTREE STREET, N. E., ATLANTA 30308

WEISS, HARVEY A. 29 ACT PL
6500 VERNON WOODS DR., N.E., ATLANTA 30328

WEITZ, FRANK 29 ACT PD
401 PEACHTREE STREET, N.E., ATLANTA 30308

WELCH, ANDREW J. 29 A OR
300 BOULEVARD, N.E., ATLANTA 30312

WELLS, ROBERT E. 29 ACT OR
1938 PEACHTREE RD., NW, ATLANTA 30309

WENGER, JULIUS 29 S I
1670 CLAIRMONT RD., N. E., ATLANTA 30329

WENGER, NANETTE K. 29 A
80 BUTLER ST. S. E., ATLANTA 30303

WEST, J. HERBERT 29 ACT I
960 JOHNSON FERRY RD., N.E., ATLANTA 30342

WEST, ROBERT M. 29 ACT
1134 MAIN ST., FOREST PARK 30050

WHALEY, WILLIAM H. 29 ACT
3250 HOWELL MILL RD., N.E., ATLANTA 30327

WHIDDEN, DESIDERIUS C. 29 ACT SL
490 PEACHTREE ST., ATLANTA 30308

WHIPPLE, ROBERT L., JR. 29 ACT I
384 PEACHTREE ST., N. E., ATLANTA 30308

WHISNANT, CHARLES L., JR. 29 ACT I
1999 CLIFF VALLEY WAY, N.E., ATLANTA 30329

WHITAKER, WM. G., JR. 29 ACT SL
35 COLLIER RD., N.W., ATLANTA 30309

WHITE, PERRY M. 29 ACT OR
340 BOULEVARD, N. E., ATLANTA 30312

WHITE, RONALD P. 29 ACT EM
340 BOULEVARD, N.E., ATLANTA 30312

WHITESIDES, THOMAS E.,JR. 29 ACT OR
EMORY UNIV. CLINIC, ATLANTA 30322

WHITNEY, DOUGLASS G. 29 ACT SL
353 PARKWAY DR., N.E., ATLANTA 30312

WHYTE, H. JORDAN 29 ACT D
307 E. JOSEPHINE ST., SAN ANTONIO,TX 78206

WIEGAND, STEWART E. 29 ACT D
EMORY UNIVERSITY, ATLANTA 30322

WIENER, JERRY M. 29 ACT P
1075 W. CONWAY DR., ATLANTA 30327

WIGGINS, ROY A., JR. 29 ACT I
1938 PEACHTREE RD., N. W., ATLANTA 30309

WILBER, JOSEPH A. 29 ACT
300 INTERSTATE N., ATLANTA 30327

WILCOX, ROBERT B. 29 ACT L
490 PEACHTREE ST., N.E., ATLANTA 30308

WILDSTEIN, GILBERT 29 ACT TS
490 PEACHTREE ST., N. E., ATLANTA 30308

WILHELM, JOHN A. 29 A FP
275 FIFTH ST., N.W., ATLANTA 30318

WILKIEMEYER, RALPH M. 29 ACT L
3250 HOWELL MILL RD., ATLANTA 30327

WILKINS, S. A., JR. 29 ACT SU
EMORY UNIV. CLINIC, ATLANTA 30322

WILLEY, LOY W. 29 ACT OPH
1275 CLEVELAND AVE., EAST POINT 30344

WILLIAMS, GEO. A. 29 DES OBG
710 PEACHTREE ST., N.E., ATLANTA 30308

WILLIAMS, G FRASER 29 ACT OBG
2945 STONE HOGAN RD., CON. S.W., ATL 30331

WILLIAMS, JOSEPH P., JR. 29 A NS
NO CURRENT ADDRESS

WILLIAMS, RALPH CHESTER 29 A PH
2573 BIRCHWOOD DR., N.E., ATLANTA 30305

WILLINGHAM, ROBT. T., JR. 29 ACT
35 COLLIER RD., N.W., ATLANTA 30309

WILMER, JOHN GRANT 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WILSON, COLON H., JR. 29 ACT I
1365 CLIFTON RD., N. E., ATLANTA 30322

WILSON, FRANK L., JR. 29 ACT SU
35 COLLIER RD., N.W., ATLANTA 30309

WILSON, JOHN P. 29 ACT SU
315 BOULEVARD, N.E., ATLANTA 30312

WILSON, J. S. 29 ACT I
490 PEACHTREE ST., N.E., ATLANTA 30308

WILSON, LOUIS A. 29 ACT OPH
NO CURRENT ADDRESS

WILSON, RICHARD 29 DES N
47 INTERLOCHEN DR., N. E., ATLANTA 30305

WINNER, JONATHAN O. 29 ACT PO
6500 VERNON WOODS DR., N.E., ATLANTA 30328

WOHLGEMUTH, STEPHEN A. 29 ACT I
41 NELSON ST., BARTOW MED. CLN., CTV 30120

WOLFF, BERNARD P. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WOLFF, JOHN MCD. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WOLFMAN, RICHARD M. 29 ACT R
1000 JOHNSON FERRY RD., N.E., ATL 30342

WOOD, MARCELLA D. 29 DES PD
3764 BRIARCLIFF RD., N.E., ATLANTA 30345

WOOD, R. HUGH 29 DES I
923 CASTLE FALLS DR., N. E., ATLANTA 30329

WOOD, ROBERT W., JR. 29 ACT GR
1938 PEACHTREE RD., N.W., ATLANTA 30309

WOOD, WILLIAM A., JR. 29 ACT I
33 PONCE DE LEON AVE. N.E., ATLANTA 30308

WOODARD, JOHN R. 29 ACT L
1365 CLIFTON RD., N.E., ATLANTA 30322

WOODSIDES, KENNETH T. 29 ACT IND
620 PEACHTREE ST., N.E., ATLANTA 30308

WOODSON, G. C., JR. 29 ACT I
6500 VERNON WOODS DR., N.E., ATLANTA 30328

WOODWARD, STEPHEN C. 29 A
GEORGETOWN MED. SCH., WASHINGTON, DC 20009

WOODY, EDGAR, JR. 29 ACT I
35 COLLIER RD., N.W., ATLANTA 30309

WORTH, JACK J., JR. 29 ACT SL
490 PEACHTREE ST., N. E., ATLANTA 30308

WRIGHT, CHAS. K. 29 ACT OBG
35 COLLIER RD., N.W., ATLANTA 30309

YAGER, HOWARD S. 29 ACT FP
3150 MAPLE DR., N.E., ATLANTA 30305

YAMPOLSKY, JOSEPH 29 DES PD
150 ROBIN HOOD RD., N. E., ATLANTA 30309

YANCEY, ASA G. 29 ACT SL
35 BUTLER ST., S.E., ATLANTA 30303

YARBROUGH, J. F. 29 ACT ANES
384 PEACHTREE ST., N. E., ATLANTA 30308

YARN, CHARLES P., JR. 29 ACT PL
35 COLLIER RD., N.W., ATLANTA 30309

YAUGER, JOHN THOMAS 29 ACT
353 PARKWAY DR., N.E., ATLANTA 30312

YOBS, ANNE ROOF 29 S PATH
2687 OVERLOOK DR., N.E., ATLANTA 30345

YOCHEM, AUGUST S., JR. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329

YU, FRANK 29 ACT ANES
159 FORREST AVE., N. E., ATLANTA 30303

YUCEL, VEHBI E. 29 ACT PM
2040 RIDGEWOOD DR., N.E., ATLANTA 30307

ZAKI, SALEH A. 29 ACT PATH
50 COCA COLA PL., SE, ATLANTA 30303

ZAYAS, LUIS P. DE 29 ACT FP
33 S.W. UPPER RIVEROLE RD., RIVERDLE 30224

ZIMMERMAN, MARK J. 29 ACT OBG
340 BOULEVARD, N. E., ATLANTA 30312

ZWIREN, GERALD T. 29 ACT PD
1901 CENTURY BLVD., N. E., ATLANTA 30345

30—GLYNN

ADDISON, BENJAMIN ALFRED 30 ACT SL
2432 PARKWOOD DRIVE, BRUNSWICK 31520

ADICKES, H. F., JR. 30 ACT P
5 RETREAT PL., ST. SIMONS ISLAND 31522

ARMSTRONG, NATHANIEL E. 30 ACT SU
P.O. BOX 1258, BRUNSWICK 31520

ARRAS, MILTON J. 30 ACT PATH
P.O. BOX 1518, BRUNSWICK 31520

AUSTIN, WM. F. 30 ACT
3011 KEMBLE, BRUNSWICK 31520

AVERA, JOHN B. 30 DEI
2560 TARA LA., BRUNSWICK 31520

BOYD, HARTWELL 30 DEI OBG
P. O. BOX 1738, ST. SIMONS ISLAND 31522

BRITT, C. S. 30 DES FP
P.O. BOX 1078, ST. SIMONS ISLAND 31522

BROWN, DWIGHT J., JR. 30 ACT OBG
3020 SHRINE RD., BRUNSWICK 31520

BROWN, JOSEPH E. 30 ACT OR
3104 SHRINE RD., BRUNSWICK 31520

BRUCE, DOUGLAS A. 30 ACT PD
520 OCEAN BLVD., ST. SIMONS IS. 31522

CHANEY, RALPH H., JR. 30 ACT ANES
P.O. BOX 776, BRUNSWICK 31520

CLARK, ROLAND B. 30 ACT OPH
2705 WILDWOOD DR., BRUNSWICK 31520

COE, F. M. 30 ACT OR
2601 PARKWOOD DR., BRUNSWICK 31520

EGAN, RICHARD W. 30 ACT SU
2432 PARKWOOD DR., BRUNSWICK 31520

ENGEL, M. F. 30 ACT D
3114 SHRINE RD., BRUNSWICK 31520

FIX, RICHARD M. 30 ACT PD
2705 WILDWOOD DR., BRUNSWICK 31520

FLOURNOY, HENRY W. 30 ACT OBG
2444 PARKWOOD DR., BRUNSWICK 31520

FRIEDRICH, ERIC W. 30 ACT OTO
2705 WILDWOOD DR., BRUNSWICK 31520

FUTCH, C. B. 30 ACT SL
2432 PARKWOOD DR., BRUNSWICK 31520

GALIN, A. N. 30 DEI FP
P.O. BOX 1055, ST. SIMONS IS. 31522

GALLOWAY, BENJAMIN THOMAS 30 ACT SL
3010 HAMPTON, BRUNSWICK 31520

GALLOWAY, LOUISE J. 30 ACT ANES
2850 WILDWOOD DR., BRUNSWICK 31520

GLUCKSMAN, MICHEL A. 30 ACT U
2705 WILDWOOD DR., BRUNSWICK 31520

GOWEN, JAMES F. 30 ACT OBG
2444 PARKWOOD DR., BRUNSWICK 31520

HAGEN, ARTHUR R. 30 ACT OR
3010 HAMPTON AVE., BRUNSWICK 31522

HAMILTON, NEWELL M. 30 ACT PD
2001 GLOUCESTER ST., BRUNSWICK 31520

HARDEN, W. E. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

HICKS, JAMES M. 30 ACT OALR
1005 LANIER BLVD., BRUNSWICK 31520

HIGHTOWER, JOHN A. 30 ACT I
4101 RIVERSIDE DR., BRUNSWICK 31520

HOBSON, JOHN L. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

HUNT, JESSE L. 30 ACT
BOX 1518, BRUNSWICK 31520

INMAN, WM. O., JR. 30 ACT FP
2700 PARKWOOD DR., BRUNSWICK 31520

JENNINGS, E. R. 30 ACT SU
2432 PARKWOOD DR., BRUNSWICK 31520

JOHNSON, C. M. 30 ACT FP
520 OCEAN BLVD., ST. SIMONS IS. 31522

JONES, HURLEY O., JR. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

JOSEY, JOHN S. 30 ACT OPH
3010 HAMPTON AVE., BRUNSWICK 31520

KIRCHMAN, HERBERT 30 ACT
403 G. STREET, BRUNSWICK 31520

LUPO, CARL W. 30 DES ALR
P. O. BOX 1057, ST. SIMONS ISLAND 31522

MANNING, DONALD H. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

MAYO, EDWIN A. 30 ACT FP
2601 PARKWOOD DR., BRUNSWICK 31520

MCCULLY, JAMES G. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

MITCHELL, FRANK B., JR. 30 ACT SU
3011 KEMBLE AVENUE, BRUNSWICK 31520

MOORE, HAYWOOD L. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

NOBLE, CARL W. 30 A FP
205 1/2 MALLORY ST., SIMONS ISL. 31522

OSTA, SALIM M. 30 ACT ON
520 OCEAN BLVD., ST. SIMONS IS. 31522

OWENS, JOS. L. 30 ACT TS
3010 HAMPTON AVE., BRUNSWICK 31520

PAYNE, WOODROW W. 30 ACT U
SHRINE RD., BRUNSWICK 31520

PERRY, ROBERT E., JR. 30 ACT PATH
P. O. BOX 1333, BRUNSWICK 31521

PIERCE, MART T. 30 ACT FP
P. O. BOX 1003, BRUNSWICK 31520

RASMUSSEN, WARREN A. 30 ACT PH
P.O. BOX 1219, BRUNSWICK 31520

ROBERTS, DON R., JR. 30 ACT OR
3010 HAMPTON AVE., BRUNSWICK 31520

SCHIMMEL, WALTER A. 30 ACT FP
120 COLONIAL DR., ST. SIMONS ISLAND 31522

SIMMONS, MACK 30 ACT SU
338 MAJOR WRIGHT, SIMONS ISLAND 31522

SMITH, JOHN M., JR. 30 ACT I
P. O. BOX 1059, ST. SIMONS IS. 31522

SMITH, MILLEDGE GLENN 30 ACT FP
3012 SHRINE RD., BRUNSWICK 31520

SMITH, WILLIAM JACKSON 30 ACT ANES
GLYNN BRUNSWICK HOSPITAL, BRUNSWICK 31521

SNYDER, WILLARD A. 30 ACT
2700 PARKWOOD DR., BRUNSWICK 31520

STRICKLAND, AVERY W. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

TAYLOR, HOWARD P. 30 ACT FP
COTTAGE 21B, SEA ISLAND 31561

THAGARD, ROY FRANK 30 ACT PD
2601 PARKWOOD DRIVE, BRUNSWICK 31520

TUTEN, CARROLL 30 ACT OPH
3011 KEMBLE AVE., BRUNSWICK 31520

VALENTE, L. A. 30 ACT SU
1801 REYNOLDS STREET, BRUNSWICK 31520

VAN DYKE, PAUL B. 30 OES FP
P.O. DRAWER N, BRUNSWICK 31520

WADDELL, PEARL B. 30 R PD
1631 LAWTON LANE, LAKELAND, FLA 33803

WEISS, EDWARD A. 30 ACT N
3010 HAMPTON AVE., BRUNSWICK 31520

WHEELER, GEO. B., III 30 ACT OBG
3020 SHRINE RD., BRUNSWICK 31520

WILLIS, TOM V., JR. 30 ACT SU
2601 PARKWOOD DR., BRUNSWICK 31520

WILSON, C. A., JR. 30 ACT FP
P.O. BOX 151B, BRUNSWICK 31520

31—GORDON

BILLINGS, J. E. 31 OE1 FP
CALHOUN 30701

BISHOP, JOSEPH A. 31 ACT FP
103 S. RIVER ST., CALHOUN 30701

DALTON, WILLIAM E. 31 ACT FP
105 E. 40TH DR., CALHOUN 30701

HALL, W. O. 31 ACT SU
CALHOUN 30701

LANG, LEWIS R. 31 ACT FP
CALHOUN 30701

PURCELL, BILL 31 ACT FP
CALHOUN 30701

RABB, J. L. 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701

STEELE, BYRON HAROLD 31 ACT FP
FAIRMOUNT 30139

THOMPSON, WILLIAM R. 31 ACT
CALHOUN 30701

WALTER, R. O. 31 ACT FP
CALHOUN 30701

33—HABERSHAM (Towns)

GARRISON, O. F. 33 OE5 FP
CLARKESVILLE 30523

GARRISON, FLETCHER D. 33 ACT FP
912 WAYSIDE ST., CORNELIA 30531

HICKS, L. G., JR. 33 ACT ANES
CLARKESVILLE 30523

HODGES, THOMAS L. 33 ACT I
WILDWOOD CIRCLE, CLARKESVILLE 30523

LUMSDEN, THOMAS N. 33 ACT FP
P. O. BOX 45, CLARKESVILLE 30523

NICHOLSON, GEORGE T. 33 ACT FP
CORNELIA 30531

ROBERTS, B. J. 33 A I
MED. DIR., DIST. 22, TOCCOA 30577

SWAIN, BRUCE 33 ACT FP
CLARKESVILLE 30523

THAMES, FRANK M., JR. 33 ACT FP
BOX 367, DEMOREST 30535

WALTER, AUSTIN J. 33 ACT FP
SAUTEE 30571

WINDHAM, ADDIS D., SR. 33 ACT FP
BOX 367, DEMOREST 30535

34—HALL (Dawson, Lumpkin, White)

ACREE, JOHN W. 34 ACT FP
HIAWASSEE 30546

ADDISON, WINNIFRED A. 34 ACT OBG
1144 VINE ST., N.E., GAINESVILLE 30501

ALDAY, JAMES M., JR. 34 ACT OR
650 BROAD ST., S.E., GAINESVILLE 30501

ALLEN, CALVIN H., JR. 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501

ANDERSON, ROBERT H., JR 34 ACT SU
194 GOLD ST., GAINESVILLE 30501

BANKS, RAFE, JR. 34 ACT U
290 ENOTA DR., N. E., GAINESVILLE 30501

BARKER, EDWARD C. 34 ACT FP
HALL CO HOSP., GAINESVILLE 30501

BATES, JACK M. 34 ACT P
500 SPRING ST., N.W., GAINESVILLE 30501

BLACK, WILEY S. 34 ACT SU
1114 VINE ST., N.E., GAINESVILLE 30501

BLACKSHEAR, STUART G. 34 ACT SU
1114 VINE ST., N. E., GAINESVILLE 30501

BLOODWORTH, AUGUSTUS F. 34 ACT I
109B S. ENOTA, N. E., GAINESVILLE 30501

BRADLEY, CHARLES K. 34 ACT OPH
112B VINE ST., GAINESVILLE 30501

BROWN, P.F., JR. 34 ACT SU
1114 VINE ST., N.E., GAINESVILLE 30501

BROWN, THOMAS D., JR. 34 ACT OTC
304 ENOTA DR., GAINESVILLE 30501

BURNS, JAMES R., JR. 34 ACT FP
700 S. ENOTA CR., N. E., GAINESVILLE 30501

BURNS, JOHN KNOX, III 34 ACT OBG
1100 VINE STREET, GAINESVILLE 30501

BUTTS, JAMES A. 34 ACT I
1732 VALLEY RD., N.E., GAINESVILLE 30501

DIXON, P.K. 34 ACT SU
1114 VINE ST., N.E., GAINESVILLE 30501

DURISCH, LAWRENCE L. 34 ACT OTC
304 ENOTA DR., GAINESVILLE 30501

ESTES, EDWARD E., JR. 34 ACT U
290 ENOTA DRIVE, N.E., GAINESVILLE 30501

FERRELL, WM. C. 34 ACT R
HALL CO. HOSPITAL, GAINESVILLE 30501

FRENCH, JAMES B. 34 ACT OBG
1100 VINE ST., GAINESVILLE 30501

GARLAND, JOHN W., III 34 ACT P
500 E. SPRING ST., GAINESVILLE 30501

GARNER, W. R. 34 OE5 I
RT. 12, BOX 163-I, GAINESVILLE 30501

GEIGER, C. LEONARD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501

GHENT, OLIVER T. 34 R R
HALL CO. HOSP., GAINESVILLE 30501

GILBERT, BEN P. 34 ACT PD
650 BROAD ST., S.E., GAINESVILLE 30501

GOWDER, GEORGE D., JR. 34 ACT
P. O. BOX 726, BLAIRSVILLE 30512

GRANT, ROBERT 34 ACT OBG
174 PINE ST. SE, GAINESVILLE 30501

HARDMAN, BILLY S. 34 ACT OBG
420 BROAD ST., GAINESVILLE 30501

HEATON, SAMUEL A., JR. 34 A FP
LAURENS CO. HEALTH DEPT., DUBLIN 31021

HOPKINS, RALPH D. 34 ACT R
HALL CO. HOSP., GAINESVILLE 30501

JACKSON, BILLY JOE 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501

JAMES, FLOYD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501

JENNINGS, HENRY S., JR. 34 ACT I
710 BROAD ST., S.E., GAINESVILLE 30501

JOHNSON, ALLYN C., JR. 34 ACT I
429 E. SPRING STREET, GAINESVILLE 30501

JOHNSTON, JOSEPH F. 34 ACT ANES
RED OAK DR., RT. B, GAINESVILLE 30501

JOINER, HARTWELL 34 DE5 I
319 N. BRADFORD ST., GAINESVILLE 30501

JORDAN, TOMMY H. 34 ACT P
500 SPRING ST., N.E., GAINESVILLE 30501

KEITH, THOMAS L. 34 ACT ANES
ANES. ASSOC. OF GAINESVILLE, GAINESVI 30501

KELLEY, CHARLES N. 34 ACT I
710 BROAD ST., GAINESVILLE 30501

KENIMER, BARRY K. 34 ACT ANES
HALL COUNTY HOSP., GAINESVILLE 30501

LANCASTER, HOMER H. 34 DE5 FP
P. O. BOX 651, GAINESVILLE 30501

LANGSTON, WILLIAM T. 34 ACT PD
650 BROAD ST., S.E., GAINESVILLE 30501

LEIGH, JAMES H., JR. 34 ACT SU
194 GOLD ST., GAINSVILLE 30501

LITTLE, CHARLES H. 34 ACT OR
700 S. ENOTA CR., N.E., GAINESVILLE 30501

LONG, HAROLD G. 34 ACT
P. O. BOX 186, CAHLONEGA 30533

LUKE, DANIEL R. 34 ACT FP
1144 VINE ST., N. E., GAINESVILLE 30501

MARRINER, E. F. 34 ACT OCM
CHICOPEE MFG. CO., GAINESVILLE 30501

MARTIN, LEE A. 34 ACT U
290 S. ENOTA DR., GAINESVILLE 30501

MCALISTER, BRADWELL R. 34 ACT OR
650 BROAD ST., S.E., GAINESVILLE 30501

MCCARVER, W. C., JR. 34 ACT FP
200 PRIOR ST., S.E., GAINESVILLE 30501

MCCRUM, B. A. 34 ACT OBG
420 E. BROAD ST., GAINESVILLE 30501

MORRIS, LARRY A. 34 ACT PD
650 BROAD ST., S.E., GAINESVILLE 30501

MURRAY, HAMIL 34 ACT PATH
HALL COUNTY HOSPITAL, GAINESVILLE 30501

NEWMAN, HARVEY M. 34 ACT PD
650 BROAD ST. S.E., GAINESVILLE 30501

NICHOLSON, W. LANIER 34 ACT FP
HIAWASSEE 30546

PEACOCK, RAY LOWELL, JR. 34 ACT PD
274 ENOTA DR., N.E., GAINESVILLE 30501

POOL, LELAND L. 34 ACT ANES
HALL CO. HOSPITAL, GAINESVILLE 30501

POOLE, SAMUEL O. 34 ACT I
710 BROAD ST., S.E., GAINESVILLE 30501

RABB, FORTE C. 34 ACT O
327 NORTHSIDE DR., N.W., GAINESVILLE 30501

RAUCH, SAMUEL DEAN 34 ACT I
710 BROAD ST., GAINESVILLE 30501

REED, JOHN H., JR. 34 ACT OPH
112B VINE ST., N. E., GAINESVILLE 30501

RICHARDSON, RUSSELL E. 34 ACT FP
HALL CO. HOSP., GAINESVILLE 30501

SMITH, MARTIN H. 34 ACT PD
274 ENOTA DR., N. E., GAINESVILLE 30501

SPEAR, J. LOUIS 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501

STRIBLING, WARREN DICKEY 34 ACT I
710 BROAD ST., S.E., GAINESVILLE 30501

STRITTMATTER, JAMES C. 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501

TETHER, ROBERT S. 34 ACT SL
194 GOLD ST., N.E., GAINESVILLE 30501

THOMPSON, WILBUR J. 34 ACT OBG
1144 VINE ST., N.E., GAINESVILLE 30501

VALENTINE, H. E., JR. 34 ACT I
429 SPRING ST., S. E., GAINESVILLE 30501

WALKER, C. J., JR. 34 ACT FP
242 ENOTA DR., N.E., GAINESVILLE 30501

WARD, EUGENE L. 34 ACT OALR
P. O. BOX 13, GAINESVILLE 30501

WATTS, JERALD L. 34 ACT OR
430 WASHINGTON ST., N.E. GAINESVILLE 30501

WHITE, WILLIAM H., JR. 34 ACT OBG
1100 VINE ST., N.E., GAINESVILLE 30501

WHITWORTH, C. W. 34 ACT OALR
P. O. BOX 1159, GAINESVILLE 30501

WOODWARD, J. G. 34 A FP
OAKLONEGA 30533

WRIGHT, ASBURY O., JR. 34 ACT O
327 NORTHSIDE DR., N.W., GAINESVILLE 30501

WRIGHT, JAMES R. 34 ACT OPH
301 NORTHSIDE DR., N.W., GAINESVILLE 30501

36—PEACH BELT
(Houston, Macon, Peach)

ADAMS, J. FRED 36 DES FP
MONTEZUMA 31063

ADAMS, THOMAS M. 36 ACT
MONTEZUMA 31063

ARNALL, JOHN ROBERT 36 ACT FP
PERRY 31069

BARROSO, CARLOS H. 36 ACT U
P. O. BOX 728, WARNER ROBINS 31093

BEARD, CARL L. 36 ACT OBG
105 BRIARCLIFF, WARNER ROBINS 31093

BLUE, JACOB S. 36 S IND
CIVILIAN CLINIC, WARNER ROBINS AFB 31094

BOHANAN, G. WAYNE 36 ACT R
HOUSTON CO. HOSP., WARNER ROBINS 31093

BROWN, ELBERT H. 36 ACT FP
212 HOSPITAL DR., WARNER ROBINS 31093

CARTER, ROBERT A. 36 ACT
212 HOSPITAL DR., WARNER ROBINS 31093

CRAWFORD, CARL L. 36 ACT FP
1410 WATSON RD., WARNER ROBINS 31093

DANIELL, DUREN 36 DES FP
4573 N. BEECHWOOD DR., MACON 31204

DUKE, JOHN F., III 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030

ENGLISH, INMAN C. 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093

FUSSELL, DANIEL O. 36 ACT I
212 HOSPITAL DR., WARNER ROBINS 31093

GRANTHAM, V. J. 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030

GRAY, DALE A. 36 ACT FP
6520 NORTHLAND AVE., ALBUQUERQUE, NM 87111

HARDEN, CLIFFORD B. 36 ACT P
212 HOSPITAL DRIVE, WARNER ROBINS 31093

HARVEY, DAVID N., III 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093

HENDRICK, A. G. 36 ACT FP
1100 SWIFT ST., PERRY 31069

HERNANDEZ, FERNANDO G. 36 ACT I
212 HOSPITAL DR., WARNER ROBINS 31093

HULSEY, W. G. 36 ACT
1115 MORNINGSIDE DR., PERRY 31069

HUSSEINI, MAJED W. 36 ACT ANES
P. O. BOX 886, TUSCALOOSA, ALA. 35401

IVEY, C. RAY, JR. 36 ACT FP
102 HOSPITAL DR., WARNER ROBINS 31093

LUCAS, WALLACE 36 ACT FP
613 E. DYKES ST., COCHRAN 31014

MANNING, JOHANN R. 36 ACT OBG
105 BRIARCLIFF RD., WARNER ROBINS 31093

MARSHALL, A. SMOAK 36 ACT SL
725 N MACON ST., FORT VALLEY 31030

MCEVER, V. W., JR. 36 ACT SL
212 HOSPITAL DR., WARNER ROBINS 31093

MCFALL, VORIS F. 36 ACT SL
WESTVIEW DRS. BLDG., FORT VALLEY 31030

MELVIN, PERRY O. 36 ACT FP
124 HOSP. DR., WARNER ROBINS 31093

MESERVE, FRANCIS BRUCE 36 ACT
121 N. DAVIS DR., WARNER ROBINS 31093

MILES, MARILYNN L. 36 ACT PD
1876 WATSON BLVD., WARNER ROBINS 31093

MORRIS, A. J. 36 ACT SL
MONTEZUMA 31063

NATHAN, DANIEL E. 36 ACT FP
FORT VALLEY 31030

PILCHER, B. LAMAR 36 ACT R
HOUSTON CT. HOSP., WARNER ROBINS 31093

RAYNOR, LUTHER K., JR. 36 ACT OBG
507 N. HOUSTON RD., WARNER ROBINS 31093

SANDERS, F. HUNT 36 ACT ANES
212 HOSPITAL DR., WARNER ROBINS 31093

SCHARF, FORREST L. 36 ACT PATH
P.O. BOX 1467, WARNER ROBINS 31093

SEAY, E. PAXTON 36 ACT
BOX 208, FT. VALLEY 31030

SENG, BARRY S. 36 ACT FP
212 HOSP. DR., WARNER ROBINS 31093

SEVERS, RONALD G. 36 ACT SL
DOCTORS CLINIC, WARNER ROBINS 31093

SPEARS, WENTFORD A. 36 ACT OALR
212 HOSPITAL DR., WARNER ROBINS 31093

SPIVEY, JAMES W. 36 ACT OR
124 HOSPITAL DR., WARNER ROBINS 31093

TALBERT, WM. G., JR. 36 ACT FP
212 HOSPITAL DR., WARNER ROBINS 31093

VINSON, FRANK 36 DES FP
FORT VALLEY 31030

WEEMS, H. E., JR. 36 ACT FP
PERRY 31069

WYNNE, MORGAN D., JR. 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093

37—JACKSON-BANKS

CRENSHAW, JOHN T. 37 ACT FP
P. O. BOX 219, JEFFERSON 30549

GRIFFETH, JOE L. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529

HOLLOWAY, EMORY W., JR. 37 A FP
P. O. BOX 126, COMMERCE 30529

PITTMAN, O. C. 37 ACT
COMMERCE 30529

ROGERS, A. A. 37 DES FP
COMMERCE 30529

ROGERS, A.A., JR. 37 ACT FP
COMMERCE 30529

SCOGGINS, P. T. 37 DES FP
COMMERCE 30529

TURK, L. N., JR. 37 ACT SL
P. O. BOX 52, HOMER 30547

VICKERY, S. A. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529

39—JEFFERSON

BRYANT, V. L. 39 DES
WAGLEY 30477

OUMAIS, ALCIO F. 39 ACT SL
1067 PEACHTREE ST., LOUISVILLE 30434

FARRIS, JOHN J. 39 ACT
BARTOW 30413

PILCHER, JAMES W. 39 ACT I
211 E. 7TH ST., LOUISVILLE 30434

REVELL, WALTER J. 39 ACT
P.O. BOX 5, LOUISVILLE 30434

WILLIAMS, CHARLES ROY 39 ACT FP
WAGLEY 30477

YUN, IN W. 39 ACT FP
809 ESTELLE ST., WRENS 30833

42—LAURENS
(Johnson)

AQUILAR, JUAN J. 42 S SL
VA CENTER, DUBLIN 31021

AVERA, BERTRAM PRICE, JR. 42 S I
VA HOSPITAL, DUBLIN 31021

BELL, J. A., JR. 42 ACT FP
DUBLIN MEDICAL ARTS CENTER, DUBLIN 31021

BRANTLEY, J. C. 42 DES FP
WRIGHTSVILLE 31096

BUSH, JAMES L. 42 S OALR
VETERANS HOSPITAL, DUBLIN 31021

BUVINGER, R. S. 42 S
VA CENTER, DUBLIN 31021

CABRERA-CICERO, ORLANDO 42 S SL
VA CENTER, DUBLIN 31021

CAMPBELL, CLARENCE G., JR 42 ACT R
LAURENS CO. HOSP., DUBLIN 31021

CARSWELL, NELSON S., JR. 42 ACT PD
MEDICAL ARTS CENTER, DUBLIN 31021

CHUNG, SOONG PYO 42 ACT PATH
VA CENTER, DUBLIN 31021

COLEMAN, FRED J. 42 ACT SL
106 N. CHURCH ST., DUBLIN 31021

DODD, WILLIAM ASA 42 ACT FP
P.O. BOX 257, WRIGHTSVILLE 31096

DUPREE, J. T. 42 S SL
VA CENTER, DUBLIN 31021

FERNANDEZ, B. P. 42 S I
V. A. CENTER, DUBLIN 31021

FITZGERALD, EDMUND M., JR. 42 S I
VA CENTER, DUBLIN 31021

FRANCO, JAIME 42 ACT PATH
LAURENS MEM. HOSP., DUBLIN 31021

GLOVER, RILEY M. 42 ACT R
LAURENS MEM. HOSP., DUBLIN 31021

GOODWIN, FRANKLIN H. 42 S I
V A CENTER, DUBLIN 31021

HAMILTON, WALTON W. 42 S R
2333 KINGS WAY, AUGUSTA 30904

HENDRICKS, CHAS M., JR. 42 S I
V A CENTER, DUBLIN 31021

JOHNSON, OTTO B., JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021

JONES, EDWARD G. 42 S
VA HOSPITAL, DUBLIN 31021

KAVURI, SURENDRANATH 42 ACT PD
112 ROWE ST., DUBLIN 31021

KIBLER, JAMES A. 42 ACT P
420 ACADEMY AVE., DUBLIN 31021

KIRKLAND, JAMES J. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021

LONGINO, GRADY E. 42 ACT I
VA CENTER, DUBLIN 31021

MADDRY, EDGAR L. 42 S AOM
VA CENTER, DUBLIN 31021

MORTON, JOHN B. 42 ACT I
V. A. CENTER, DUBLIN 31021

MULLIS, KENNETH L. 42 ACT FP
309 BELLEVUE AVE., DUBLIN 31021

ODANIEL, J. F. 42 ACT FP
107 ROWE ST., DUBLIN 31021

OLIVER, ROBERT W., JR. 42 ACT SU
508 ACADEMY AVE., DUBLIN 31021

PRADA, OSCAR 42 ACT FP
112 ROWE ST., DUBLIN 31021

PRICE, QUENTIN 42 ACT FP
205 W. GAINES ST., DUBLIN 31021

PROCTOR, ROBERT F. 42 ACT I
VA CENTER, DUBLIN 31021

REEVES, SEAB E. A. 42 ACT ANES
219 WAVERLY DR., DUBLIN 31021

ROCHE, WM. PATRICK, JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021

ROWLAND, J. ROY, JR. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021

SATHE, ANAND J. 42 ACT OBG
105 VERNON ST., DUBLIN 31021

SKINNER, JOHN J., JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021

SMITH, MALCOLM M. 42 ACT FP
SHAMROCK COURT APT., DUBLIN 31021

STAPLETON, JAMES W. 42 S OR
VA HOSPITAL, DUBLIN 31021

TANNER, GEO. E. 42 ACT SL
606 ACADEMY AVE., DUBLIN 31021

VIERA, MAX 42 S I
VA CENTER, DUBLIN 31021

WATKINS, W. M. 42 ACT SU
NO CURRENT ADDRESS

44—McDUFFIE (Columbia)

AVERITT, THOMAS E. 44 ACT FP
P. O. BOX 408, THOMSON 30824

LEMLEY, JOHN W. 44 ACT FP
DOCTORS BLDG., THOMSON 30824

LEROY, ALBERT G. 44 ACT FP
THOMSON 30824

MAXWELL, EDGAR J., JR. 44 ACT SU
W. HILL ST., THOMSON 30824

MIDDLEBROOKS, T. W. 44 ACT FP
THOMSON 30824

VAUGHAN, WILLIAM L. 44 ACT SL
KNOX PLAZA, THOMSON 30824

WHALEY, MORGAN N. 44 ACT FP
NO CURRENT ADDRESS

45—MERIWETHER-HARRIS-TALBOT

BENNETT, ROBERT L. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

BENNETT, V. H. 45 OE5 FP
801 RIVERHILL DR., ATHENS 30601

CALVERT, WILSON C. 45 ACT I
WARM SPRINGS FOUNDATION, WARM SPRINGS 31830

CHAMBLESS, MIRIAM WALKER 45 ACT FP
HAMILTON 31811

CHAMBLESS, WILLIAM G. 45 ACT FP
HAMILTON 31811

COLLINS, JAMES E. 45 ACT FP
129 E. SECOND STREET, MANCHESTER 31816

HAAK, EDWARD OECKER 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

HIGGINS, ALEXIS C. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

HOFFMAN, KATHRYN A. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830

JACKSON, HENRY C. 45 ACT FP
MANCHESTER 31816

JOHNSON, J. A. 45 OE5 FP
MANCHESTER 31816

RAPER, HAL STUART 45 R
THE FOUNDATION, WARM SPRINGS 31830

REITH, PAUL L. 45 ACT OR
THE FOUNDATION, WARM SPRINGS 31830

ROBINSON, J. L. 45 ACT
P.O. BOX 481, CARROLLTON 30117

SMITH, JAMES W. 45 ACT FP
MANCHESTER 31816

WHITWORTH, JACK W. 45 ACT FP
1901 N. 2ND CT., LANETT, ALA. 36863

46—MITCHELL

ARWOOD, WILLIAM C., JR. 46 ACT
PELHAM 31779

GUNTER, OLIVER L. 46 ACT FP
34 PERRY ST., CAMILLA 31730

HUDSON, HAROLD J. 46 ACT FP
25 PERRY AVE., CAMILLA 31730

MCNEILL, A. A., JR. 46 ACT
CAMILLA 31730

POTTER, WILLIAM D. 46 ACT FP
P. O. BOX 333, CAMILLA 31730

47—MUSCOGEE (Chattahoochee)

ALVAREZ, ANGEL C. 47 ACT PD
7121 LULLWATER RD., COLUMBUS 31904

ANDERSON, PAUL D. 47 OE4 I
MARTIN ARMY HOSP., FT. BENNING 31905

ANDREWS, JAMES R. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901

BALDWIN, B. CARTER 47 ACT O
1217 PEACOCK AVE., COLUMBUS 31901

BEACH, BESSIE MAE 47 S PO
17 BALENTINE DR., GREENVILLE, S. C. 29605

BERENSON, MORTON P. 47 ACT I
2748 SUE MACK DR., COLUMBUS 31906

BERMAN, DAVE 47 ACT O
1315 4TH AVE., COLUMBUS 31901

BERRY, ARTHUR N. 47 R OBG
1730 SE. 40 ST., COLUMBUS 31904

BICKERSTAFF, HUGH J. 47 OE5 OBG
MEDICAL ARTS BLDG., COLUMBUS 31901

BLALOCK, JACK H., JR. 47 ACT I
MEDICAL ARTS BLDG., COLUMBUS 31901

BLANCHARD, MERCER 47 OE5 PD
NO CURRENT ADDRESS

BLANCHARD, MERCER C. 47 ACT PD
713 20TH ST., COLUMBUS 31904

BOYTER, HENRY H. 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901

BREWER, PHILIP L. 47 ACT TS
MEDICAL ARTS BLDG., COLUMBUS 31901

BRIGHTWELL, LARRY E. 47 ACT SL
105 DOCTORS BLDG., COLUMBUS 31901

BRILL, HARRY H., JR. 47 ACT I
1905 SEVENTH AVE., COLUMBUS 31901

BROCATO, SIMONE 47 ACT C
PHYSICIANS BLDG., COLUMBUS 31901

BURK, BILLY O. 47 A OBG
MARTIN ARMY HOSP., FT. BENNING 31905

BURR, MAX E. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31902

BUSH, JOHN 47 OE5 FP
P. O. BOX 141, COLUMBUS 31902

BUTLER, CLARENCE 47 ACT I
P. O. BOX 4195, COLUMBUS 31904

CABANISS, C. DANIEL 47 ACT I
P.O. BOX 951, COLUMBUS 31902

CARDEN, BRADLEY L. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

CARGILE, KENNETH R. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

CARPENTER, ROBERT H. 47 ACT OBG
2404 13TH ST., COLUMBUS 31906

CHASE, JERRY S. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

CHASTAIN, J. B. 47 ACT PD
1710 HILTON AVE., COLUMBUS 31906

CHIPMAN, R. A. 47 ACT SU
PHYSICIANS BLDG., COLUMBUS 31901

COHEN, MARVYN D. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901

COLLINS, FRANK B. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901

CONGER, A. B. 47 ACT SU
206 DOCTORS BLDG., COLUMBUS 31901

CONN, LEE R. M. 47 ACT SU
1914 8TH AVE., COLUMBUS 31901

CONNER, GEORGE R. 47 ACT SL
1914 8TH AVE., COLUMBUS 31901

CORNWELL, WILLIAM O. 47 A
P. O. BOX 951, COLUMBUS 31902

CORRY, ROBERT D. 47 I&R A
MEDICAL CENTER, COLUMBUS 31902

CRAIG, FREDERICK S. 47 OE1 OR
NO CURRENT ADDRESS

CROWDER, JACKSON G. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

DASHIELL, WAVERLY B. 47 ACT OBG
P. O. BOX 157, COLUMBUS 31902

DEAN, ROBERT D. 47 ACT OBG
110 DOCTORS BLDG., COLUMBUS 31901

DEATON, J. H. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

DILLARD, GARY A. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

DODELIN, R. A. 47 ACT
2300 MANCHESTER RD., STE. E1, COLUMBUS 31904

DOUGEN, CHARLES W. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

DUDLEY, A. B., JR. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

DUPONT, LOUIS 47 ACT SU
P. O. BOX 4195, COLUMBUS 31904

DURDEN, JOHN G., JR. 47 ACT SL
1915 SEVENTH AVE., COLUMBUS 31901

EATON, JAMES M., JR. 47 ACT U
ORS BLDG., COLUMBUS 31901

EDWARDS, FRANKLIN O. 47 ACT U
1430 3RD AVE., COLUMBUS 31901

EDWARDS, M. DELMAR 47 ACT SL
804 4TH AVE., COLUMBUS 31901

ELKINS, JAMES A. 47 OE1 OR
P.O. BOX 5364, COLUMBUS 31906

EPPS, GEORGE L. 47 ACT R
THE MEDICAL CENTER, COLUMBUS 31902

FLANAGAN, WM. C., JR. 47 ACT OBG
P.O. BOX 157, COLUMBUS 31902

FLOWERS, ROBERT M. 47 ACT PD
2039 WARM SPRINGS RD., COLUMBUS 31904

FOSTER, THOMAS V. 47 ACT P
1953 SEVENTH AVE., COLUMBUS 31904

FOX, BRENT 47 ACT OALR
MEDICAL ARTS BLDG., COLUMBUS 31901

GALEN, NORMAN R. 47 OE4 U
MARTIN ARMY HOSP., FT BENNING 31905

GALEN, WESLEY K. 47 ACT O
3816 CASPIAN DR., COLUMBUS 31901

GILLIAM, O. O. 47 OE5 SU
P. O. BOX 2016, COLUMBUS 31902

GOLDMAN, KENNETH L. 47 ACT SU
905 CENTER ST., COLUMBUS 31901

GOLDMAN, NORMAN I. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

GOLOSMITH, HOWARD G. 47 ACT DR
2009 WARM SPRINGS RD., COLUMBUS 31901

GRAFFAGNINO, P. C. 47 ACT DBG
MEDICAL ARTS BLDG., COLUMBUS 31901

GRAHAM, WILLIAM L. 47 ACT R
P. O. BOX 2787, COLUMBUS 31901

GRIFFIN, JACK T. 47 ACT NS
2009 WARM SPRINGS RD., COLUMBUS 31904

GRINER, WALLACE 47 ACT
5740 WILTSHIRE DR., COLUMBUS 31907

HAGLER, JAMES R. 47 ACT FP
NO CURRENT ADDRESS

HARRIS, J. HENRY WALKER 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

HAYES, WILLIAM H. 47 ACT PATH
P. O. BOX 4176, COLUMBUS 31904

HAZOURI, LOUIS A. 47 ACT NS
P. O. BOX 5306, COLUMBUS 31906

HIRSCH, JACK 47 ACT I
909 CENTER ST., COLUMBUS 31901

HORN, EDGAR B. 47 ACT SU
DOCTORS BLDG., COLUMBUS 31901

HOWARD, EDWARD K. 47 ACT SL
MEDICAL CENTER, COLUMBUS 31902

HUDSON, RONALD M. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

HUDSON, W. LLOYD 47 ACT PD
PHYSICIANS BLDG., COLUMBUS 31901

HUGHSTON, JACK C. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901

JARRELL, FLOYD C., JR. 47 ACT OALR
317 DOCTORS BLDG., COLUMBUS 31901

JARRELL, HAROLD G. 47 ACT OBG
629 20TH STREET, COLUMBUS 31904

JENKINS, CHESTER W. 47 S P
MARTIN ARMY HOSP., FT. BENNING 31906

JENKINS, W. F. 47 DE5 R
1636 DIXON DR., COLUMBUS 31906

JERNIGAN, WM. C. T. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904

JOHNSON, C. D. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904

JONES, W. R. 47 DE5 PD
3055 SAGE RD., HOUSTON, TEXAS 77000

JORDAN, W. P. 47 DE5 U
2875 EDGEWOOD DRIVE, COLUMBUS 31906

KNELLER, SHELOON 47 S SL
MARTIN ARMY HOSP., FT. BENNING 31906

KRAATZ, ROBERT 47 ACT PATH
1800 LAKEWOOD DR., PHENIX CITY AL 36867

KRAVTIN, A. J. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901

LAPIDES, LEON 47 ACT ALR
309 DOCTORS BLDG., COLUMBUS 31901

LAWLER, JACK 47 ACT OBG
629 20TH ST., COLUMBUS 31904

LIPSCOMB, GEORGE E. 47 ACT R
P. O. BOX 2787, COLUMBUS 31902

LOVE, WILLIAM G., JR. 47 ACT SL
P. O. BOX 6547, COLUMBUS 31907

MARCUS, ROBERT D. 47 ACT GIC
1962 NORTH AVE., COLUMBUS 31901

MAUGHON, BOB R. 47 ACT PN
1953 SEVENTH AVE., COLUMBUS 31904

MAZUR, W. P. 47 ACT P
P. O. BOX 6563, COLUMBUS 31907

MCALLISTER, KATHRYN 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

MCGEE, THEODORE J. 47 ACT SU
ST. FRANCIS MED. PK., COLUMBUS 31904

MEINE, FREDERICK J. 47 ACT R
1515 DARTMOUTH RD., COLUMBUS 31902

MILLER, GORDON C. 47 ACT I
2300 MANCHESTER X-WAY, COLUMBUS 31904

MOLNAR, EDMUND M. 47 ACT SU
101 DOCTORS BLDG., COLUMBUS 31901

MUNN, E. K. 47 DE5 OBG
2919 HAMILTON RD., COLUMBUS 31904

MURDOCK, ROBERT N. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

NELKEN, VIOLA D. 47 ACT ANES
DOCTORS BUILDING, COLUMBUS 31901

NEWBERRY, DAN C. 47 ACT ANES
DOCTORS BLDG., COLUMBUS 31901

NEWSOM, BRUCE C. 47 ACT SL
633 19TH ST., COLUMBUS 31901

NEWTON, JOHN S. 47 ACT OPH
317 DOCTORS BLDG., AUGUSTA 30902

OOOM, HART S. 47 ACT
P.O. BOX 2299, COLUMBUS 31902

PATTERSON, MCLEOD 47 ACT FP
1612 ELMWOOD DR., COLUMBUS 31906

PEIRCE, KENNETH E. 47 ACT AL
MEDICAL ARTS BLDG., COLUMBUS 31901

PETERS, HANS J. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31904

PURKS, W. WARREN, JR. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

RAINES, JACK A. 47 ACT P
2000 16TH AVE., COLUMBUS 31901

RHEA, JAMES W. 47 A PD
ARAMCO, BOX 2438, DHAHRAN, SAUDI ARABIA

RICE, SAMUEL T. 47 ACT U
1430 THIRD AVE., COLUMBUS 31901

RIVERS, W. P., JR. 47 ACT PD
2520 WYNNTON RD., COLUMBUS 31906

ROBERTS, DAVID B. 47 ACT OBG
2400 13TH ST., COLUMBUS 31906

ROBERTS, LUTHER J. 47 ACT SL
MEDICAL ARTS BLDG., COLUMBUS 31901

RODDENBERY, S. A. 47 ACT SL
213 DOCTORS BLDG., COLUMBUS 31901

ROOF, JACK B., JR. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

SCHILLER, HERBERT M. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31901

SCHLEY, FRANCIS B., JR. 47 ACT PD
303 11TH STREET, COLUMBUS 31901

SCHLEY, PHILIP T. 47 ACT U
OOCTORS BLDG., COLUMBUS 31901

SCHNICK, JOHN C. 47 ACT FP
MEDICAL CENTER HOSP., COLUMBUS 31902

SCHUESSLER, GEORGE 47 ACT FP
302 DOCTORS BLDG., COLUMBUS 31901

SENEVIRATNE, D. G. 47 ACT EM
710 CENTER ST., COLUMBUS 31902

SERRATO, J. C., JR. 47 ACT OR
DOCTORS BUILDING, COLUMBUS 31901

SHELTON, THOMAS G. 47 ACT I
1952 NORTH AVE., COLUMBUS 31901

SIGMAN, HOLLIS O. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

SIMPSON, MARSHALL A. 47 ACT P
BRADLEY CTR., COLUMBUS 31901

SIMPSON, WALTER W. 47 ACT EM
MEDICAL CENTER, COLUMBUS 31901

SIMS, WILLIAM G. 47 ACT PL
SUITE 212, DRS. BLDG., COLUMBUS 31901

SIZEMORE, JULIAN J., JR. 47 ACT PD
808 21ST ST., COLUMBUS 31904

SKIPWORTH, GEORGE B. 47 ACT D
711 CENTER ST., COLUMBUS 31901

SMITH, GEORGE BERTLING 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901

SMITH, HILTON E. 47 ACT FP
CROSS COUNTRY PL. OFC.PK., COLUMBUS 31907

SMITH, LUTHER J., II 47 ACT P
1953-7TH AVE., COLUMBUS 31901

SNELLING, W. R. 47 DE1 SL
2028 DELL DR., COLUMBUS 31906

SOUMA, MICKI C. 47 ACT OBG
P.O. BOX 951, COLUMBUS 31902

STAHLKUPPE, ROBERT F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

STAMEY, CHARLES C. 47 ACT OBG
629 20TH ST., COLUMBUS 31906

STAPLETON, JOHN L. 47 DE5 U
307 11TH ST., COLUMBUS 31901

STAR, FRANKLIN J. 47 ACT SU
905 CENTER ST., COLUMBUS 31901

STEIN, J. D. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

STEINHAUER, JAMES J. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

STEWART, CHARLES R. 47 ACT R
2747 CORA DR., COLUMBUS 31906

STEWART, DONALD M. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901

SULLIVAN, JAMES H. 47 ACT U
1430 3RD. AVE., COLUMBUS 31901

TALLEY, ROBERT E. 47 ACT SL
DOCTORS BLDG., COLUMBUS 31901

TAYLOR, WILLIAM M. 47 ACT R
MEDICAL CENTER, COLUMBUS 31902

TERRELL, JOE F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902

THEUS, THOMAS L. 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901

THRASH, CALVIN L., JR. 47 ACT I
2039 WARM SPRINGS RD., COLUMBUS 31901

TODD, JOHN M. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904

TURCOTTE, MAURICE R. 47 ACT
P.O. BOX 786, COLUMBUS 31906

TURNER, F. H. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901

TYRONE, NELSON O., JR. 47 ACT U
DOCTORS BLDG., COLUMBUS 31901

VAN DUYN, JOHN 47 ACT PL
DOCTORS BLDG., COLUMBUS 31901

VARNER, W. D. 47 ACT OBG
2300 MANCHESTER RD., COLUMBUS 31904

VAUGHAN, R. H. 47 ACT SL
711 CENTER, COLUMBUS 31901

VENABLE, JAMES HEISKELL 47 ACT OBG
204 MEDICAL ARTS BLDG., COLUMBUS 31901

VIGRASS, HOWARD G. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

WALLACE, ROBERT G. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

WALLER, ROY M., JR. 47 ACT FP
203 PHYSICIANS BLDG., COLUMBUS 31901

WARD, JAMES 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901

WARNOCK, RALPH P. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

WASDEN, HOWELL A. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

WATERS, DONALD B. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902

WATSON, DAVIS RONALD 47 ACT OALR
317 DOCTORS BLDG., COLUMBUS 31901

WATSON, JOHN D., JR. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902

WEBBER, JOSEPH M. 47 ACT PATH
633-19TH ST., COLUMBUS 31901

WELLS, T. W., JR. 47 DE4 OPH
MARTIN ARMY HOSP., FT. BENNING 31905

WHATLEY, GEORGE S. 47 ACT OR
2009 WARM SPRINGS RD., COLUMBUS 31904

WHITAKER, CECIL F. 47 ACT OBG
629 20TH ST., COLUMBUS 31902

WOLFF, LUTHER H. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901

WOLFF, WM. A. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901

YARBROUGH, JAMES E. 47 A
1909 IRIS DRIVE, COLUMBUS 31906

YARBROUGH, SIDNEY H., III 47 ACT OR
1310 13TH AVE., COLUMBUS 31901

YOE, LIONEL MEREDITH 47 ACT OPH
DOCTORS BLDG., COLUMBUS 31901

ZUBOWICZ, GEORGE 47 ACT P
2000 16TH AVE., COLUMBUS 31901

48—NEWTON-ROCKDALE

ABBOTT, EMILE G. 48 ACT I
2121 FLAT SHOALS RD.,CONYERS 30207

BONAU, ROGELIO 48 ACT SU
5303 ADAMS ST., COVINGTON 30209

BROOKS, CHARLES P. 48 ACT FP
NO CURRENT ADDRESS

BROWN, JOSEPH CHRISTOPHER 48 ACT FP
CONYERS 30207

CEBULA, JEROME M. 48 ACT PATH
2537 HIGHLAND DR., CONYERS 30207

FAULKNER, ROBERT L. 48 ACT FP
1022 TATE ST., COVINGTON 30209

FREYRE, ROBERT C. 48 ACT FP
943 COURT ST., CONYERS 30207

FUTCH, WILLIAM A. 48 ACT FP
CONYERS 30207

PALMER, FRED L. 48 ACT R
ROUTE 4, COVINGTON 30209

PATY, ROBERT M., JR. 48 DES SU
P. O. BOX 527, OXFORD 30267

PULLIAM, MORRIS M. 48 DE2 FP
RT. 4, ELIZABETH ST., COVINGTON 30209

PURCELL, J. W., JR. 48 ACT FP
COVINGTON 30209

SAMS, J. R. 48 DES
COVINGTON 30209

TUCK, G. G. 48 ACT FP
COVINGTON 30209

49—OCONEE VALLEY
(Greene, Hancock, Morgan)

DICKENS, C. H. 49 DES PD
903 DIXIE AVE., MADISON 30650

FERRELL, M. LYNN 49 ACT FP
325 E. BROAD ST., SPARTA 31087

GIBSON, WALLACE M. 49 ACT
106 N. JEFFERSON ST., EATONTON 31024

GREEN, GEORGE F. 49 ACT FP
325 E. BROAD ST., SPARTA 31087

LEWIS, L. K. 49 ACT
BOX 552, MADISON 30650

LEWIS, RONEL L. 49 S P
P. O. BOX 596, FT. BENNING 31905

MCGEARY, W. C., JR. 49 ACT FP
167 W. JEFFERSON ST., MADISON 30650

PAGSISIHAN, FRANCISCO H. 49 ACT SU
P.O. BOX 10, MADISON 30650

PARKER, J. LEE 49 ACT FP
GREENSBORO 30642

RHODES, WM. H., JR. 49 ACT FP
100 SCOTT ST., UNION POINT 30669

THORNTON, H. A. 49 ACT FP
P. O. BOX 326, GREENSBORO 30642

WADE, LEO J. 49 ACT FP
208 VEASEY ST., UNION POINT 30669

50—OCMULGEE
(Bleckley, Dodge, Pulaski, Wilcox)

ARNOLD, M. F. 50 ACT FP
TAYLOR MEMORIAL HOSP., HAWKINSVILLE 31036

BAKER, W. R. 50 ACT SU
HAWKINSVILLE 31036

BATTS, A. S. 50 ACT
HAWKINSVILLE 31036

BIVINS, BLAKE S. 50 ACT FP
BEECH ST., COCHRAN 31014

BRIGGS, WM. JESSE, III 50 ACT FP
MILAN 31060

COLEMAN, W. E. 50 ACT FP
HAWKINSVILLE 31036

CONNER, D. H. 50 ACT
P. O. BOX 629, EASTMAN 31023

DURHAM, W. P. 50 DES GALR
ABBEVILLE 31001

HOLDER, F. P., JR. 50 ACT SU
P. O. BOX 569, EASTMAN 31023

JUN, CHANNING S. 50 ACT SU
702 SECOND AVE. W., EASTMAN 31036

KIM, SUNG H. 50 ACT PATH
GRIFFIN ST., EASTMAN 31023

LONG, HAROLD W. 50 ACT FP
P. O. BOX 400, EASTMAN 31023

PATTERSON, GEORGE W. 50 ACT FP
DOOGE CT. HOSP., EASTMAN 31023

SMITH, R. L. 50 ACT FP
COCHRAN 31014

TSENG, GEORGE Y. 50 ACT PD
P. O. BOX 159, EASTMAN 31023

53—RANDOLF-STEWART-TERRELL

ALLEN, THOMAS M. 53 ACT FP
JOHNSON ST., DAWSON 31742

BATES, JOHN G. 53 ACT FP
201 RANDOLPH ST., CUTHBERT 31740

MARTIN, ROBERT B., III 53 ACT SU
201 RANDOLPH ST., CUTHBERT 31740

MARTIN, WALTER O. 53 ACT FP
DAWSON 31742

MAYO, EARL A., JR. 53 ACT
RICHLAND 31825

SHEFFIELD, CHARLES RAY 53 ACT FP
JOHNSON STREET, DAWSON 31742

SIMS, A. R. 53 ACT
RICHLAND 31825

WARD, CHARLES M. 53 ACT FP
107 1/2 LEE STREET, DAWSON 31742

54—RICHMOND
(Glascock, Lincoln)

ABBOTT, DON C. 54 ACT N
1220 ELLA ST.,ANDERSON,S.C. 29621

ABELE, DONALD C. 54 ACT O
MED. COLLEGE OF GA., AUGUSTA 30902

ABOUL-KHAIR, SIOKY 54 ACT I
304 JONES AVE.,WAYNESBORO 30830

AGDSTAS, W. N. 54 ACT I
1021 15TH STREET, AUGUSTA 30901

AKAMATSU, YASUYUKI 54 ACT PATH
MED. COLLEGE OF GA., AUGUSTA 30902

ALLEN, LANE H. 54 ACT
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ALLEN, MARSHALL B., JR. 54 ACT N
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ALTHISAR, H. M. 54 ACT FP
VA HOSP., AUGUSTA 30904

ANDERSON, FRANK P., JR. 54 ACT PD
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902

ASERON, CIRILO, JR. 54 ACT R
MEDICAL COLLEGE OF GA., AUGUSTA 30904

ASOKAN, SANKARAN K. 54 ACT I
MEDICAL COLLEGE OF GA. AUGUSTA 30902

AZIZ, EZZAT M. 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902

BAILEY, HENRY WRIGHT 54 ACT
1500 JOHNS RD., AUGUSTA 30904

BAILEY, JOSEPH P. 54 ACT I
TALMADGE HOSP., AUGUSTA 30902

BAILEY, T. E. 54 ACT PD
1111 ORVIS PARK AVE., AUGUSTA 30904

BARFIELD, WILLIAM E. 54 ACT OBG
1445 HARPER ST., AUGUSTA 30902

BARFIELD, WILLIAM E., JR. 54 A OBG
MED. COLLEGE OF GA., AUGUSTA 30902

BATTEY, L. L. 54 ACT I
1021 15TH STREET, AUGUSTA 30901

BAZEMORE, J. MALCOLM 54 ACT O
1467 HARPER ST., AUGUSTA 30902

BECTON, JAMES L. 54 ACT DR
1521 ANTHONY RD., AUGUSTA 30904

BEDINGFIELD, W. R., JR. 54 ACT I
N. AUGUSTA, SO. CAROLINA 29841

BELK, BEVERLY 54 ACT PD
1723 1/2 KISSINGBOWER RD., AUGUSTA 30904

BELL, J. E. 54 ACT PD
1411 GWINNETT ST., AUGUSTA 30902

BENNETT, J. W. 54 ACT PD
1467 HARPER ST., AUGUSTA 30902

BERG, EDWARD W. 54 ACT OR
MEDICAL COLLEGE OF GA., AUGUSTA 30902

BILLINGHURST, GEORGE A. 54 OE1 FP
VA HOSPITAL, COLUMBIA, S. C. 29201

BITTLE, CHARLES R. 54 ACT ANES
812 13TH ST., AUGUSTA 30902

BLALOCK, H. SHERMAN 54 ACT OR
1515 POPE AVE., AUGUSTA 30904

BLANCHARD, THOMAS W. 54 ACT U
1502 ANTHONY RD., AUGUSTA 30904

BLITCH, PIERCE G., JR. 54 ACT I
1505 WINTER ST., AUGUSTA 30904

BLIVEN, FLOYD E., JR. 54 ACT OR
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902

BOHLER, CLORINDA S. 54 ACT EM
2279 WRIGHTSBORO RD., AUGUSTA 30904

BOLLET, ALFRED J. 54 ACT I
MED. CTR., SUNNY DOWNSTATE, BROOKLYN 11203

BOTNICK, ROBERT S. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904

BOWDEN, TALMADGE A., JR. 54 ACT SU
MED. COLLEGE OF GA., AUGUSTA 30902

BOWEN, J. B. 54 ACT SU
842 GREENE ST., AUGUSTA 30902

BOWEN, JOHN L. 54 OE2 PD
P. O. BOX 1637, ORANGEBURG, S. C. 29115

BOWLES, LESTER L. 54 ACT P
P. O. BOX 4687, MARTINEZ 30907

BOYD, CLAUD A., JR. 54 ACT O
1509 ANTHONY RD., AUGUSTA 30904

BOYD, WM. S. 54 ACT OBG
1503 WINTER ST., AUGUSTA 30904

BRACKNEY, EDWIN L. 54 ACT SU
BOX 521, V A HOSP., TUSKEGEE, ALA 36083

BRANSOME, EDWIN D., JR. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

BRIDGES, HENRY B. 54 ACT DR
1413 GWINNETT ST., AUGUSTA 30902

BRIDGES, MERCER T. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904

BRIZEL, HERBERT E. 54 ACT R
1467 HARPER ST., AUGUSTA 30902

BRONSTEIN, EDWIN S. 54 ACT OBG
MED. COLLEGE OF GA., AUGUSTA 30902

BROWN, ALLEN N. 54 ACT FP
1439 ORVIS PK. AVE., F., AUGUSTA 30904

BROWN, AUDREY K. 54 ACT PD
450 CLARKSON AVE., BROOKLYN, N.Y. 11203

BROWN, JAMES A. 54 ACT OPH
1445 HARPER ST., AUGUSTA 30902

BROWN, MARK 54 ACT R
TALMADGE MEMORIAL HOSP., AUGUSTA 30902

BROWN, SOLOMON K. 54 ACT R
1467 HARPER STREET, AUGUSTA 30904

BROWN, STEPHEN W. 54 ACT R
1467 HARPER ST., AUGUSTA 30904

BRUCKNER, HOWARD L. 54 ACT OPH
905 15TH ST., AUGUSTA 30902

BRUNS, WM. L., JR. 54 ACT OBG
1430 HARPER ST., AUGUSTA 30902

BRYANS, C. I., JR. 54 ACT OBG
TALMADGE HOSP., AUGUSTA 30902

BURDISON, WM. R. 54 S
V.A. HOSPITAL, AUGUSTA 30904

BURGAMY, CLYDE A. 54 ACT OBG
DRS. HOSPITAL PLAZA AUGUSTA 30904

BURROUGHS, GERALD W. 54 ACT P
EUGENE TALMADGE MEM. HOSP., AUGUSTA 30902

CALDWELL, JOSEPH L., JR. 54 ACT SU
808 13TH ST., AUGUSTA 30901

CALVERT, JDN C. 54 ACT FP
MED. COLLEGE OF GA., AUGUSTA 30902

CARLUCCI, AGDSTINO 54 ACT
1108 CRUID PARK AVE., AUGUSTA 30904

CARR, ALBERT A. 54 ACT I
MED. COLLEGE DF GA., AUGUSTA 30902

CARRINGTON, KENNETH W. 54 ACT NS
1521 PDPE AVE., AUGUSTA 30904

CARSWELL, AUGUSTIN S. 54 ACT DR
1407 GWINNETT ST., AUGUSTA 30902

CARTER, CURTIS H. 54 ACT I
MEDICAL CDLLEGE OF GA., AUGUSTA 30902

CARTER, MARY JD 54 ACT I
MEDICAL CDLLEGE OF GEDRGIA, AUGUSTA 30902

CHAMBERS, RDY G. 54 ACT P
1423 HARPER ST., AUGUSTA 30902

CHANDLER, A. BLEAKLEY 54 ACT
MEDICAL CDLLEGE OF GEORGIA, AUGUSTA 30902

CHANDLER, JDHN L. 54 ACT DR
1515 PDPE AVE., AUGUSTA 30904

CHENG, YUNG-SHENG 54 ACT DBG
TALMADGE MEM. HDSP., AUGUSTA 30902

CHRISTIAN, J. D., JR. 54 ACT DR
1521 ANTHONY RD., AUGUSTA 30904

CLARK, PATRICIA O. 54 I&R
MCG, BDX 898, AUGUSTA 30902

CLARK, SARAH L. 54 ACT I
1280 MERRY STREET, AUGUSTA 30904

CLARK, WILLIAM L., JR. 54 ACT DR
1515 POPE AVE., AUGUSTA 30904

CLARY, THOS. L., JR. 54 ACT I
712 OBERLIN RDAD, AUGUSTA 30904

COLEMAN, BLANCHE D. 54 ACT OBG
1450 ANTHDNY RD., AUGUSTA 30904

COLLINGS, HARDLD, JR. 54 ACT N
1514 ANTHONY RD., AUGUSTA 30904

COLLINS, MYRDN D. F. 54 ACT OR
1132 DRUID PARK DR., AUGUSTA 30904

CODK, TERRENCE J. 54 ACT A1
1715 1/2 CENTRAL AVE., AUGUSTA 30904

CRANSTDN, W. J. 54 DE5 I
2749 WALTON WAY, AUGUSTA 30904

CRISLER, EUGENE C. 54 ACT R
3623 J. DEWEY GRAY CIRCLE., AUGUSTA 30904

CRDUCH, MICKEY M. 54 DE2 FP
MEDICAL CDLLEGE OF GA., AUGUSTA 30902

CUNDEY, DAVID W. 54 ACT C
1003 CHAFFEE AVE., AUGUSTA 30902

CUNDEY, PAUL E., JR. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904

CUSTY, JANE C. 54 ACT ANES
MEDICAL CDLLEGE DF GA., AUGUSTA 30902

DAITCH, RDNALD 54 ACT DBG
1021-15TH ST., AUGUSTA 30901

DANIEL, ERNEST F., JR. 54 ACT NS
2247 WRIGHTSBORD RD., AUGUSTA 30902

DENNIS, ALLEN J., JR. 54 ACT I
TALMADGE MEM. HOSP., AUGUSTA 30902

DEVDRE, MARGARET B. 54 ACT ANES
MED. COLL. OF GA., AUGUSTA 30902

DIXDN, WILLIAM L. 54 ACT SU
MCG, DEPT. SURGERY, AUGUSTA 30902

DOUGLASS, THDMAS G. 54 ACT I
1407 GWINNETT ST., AUGUSTA 30902

DUNAGAN, ODNALD 54 ACT PD
GRACEWDOD STATE HOSP., GRACEWDOD 30812

DUNLAP, DICKSON B. 54 ACT I
VA HOSP., AUGUSTA 30904

DUNN, MAURICE 54 ACT P
3012 PARK AVE., AUGUSTA 30904

DYKEN, PAUL R. 54 ACT PDN
MED. CDLLEGE OF GA., AUGUSTA 30902

ECHOLS, GEDRGE L., JR. 54 ACT PD
1021 15TH ST., AUGUSTA 30901

ECHOLS, JDSEPH M. 54 ACT OBG
1167 UNIVERSITY PL., AUGUSTA 30902

EDMONDSDN, H. T., JR. 54 ACT SU
V. A. HOSPITAL, AUGUSTA 30904

ELLINGTDN, PRESTON DAVID 54 ACT PD
824 WINDSDR CT., AUGUSTA 30904

ELLIS, RALPH G., JR. 54 ACT ANES
MEDICAL COLLEGE DF GA., AUGUSTA 30904

ELLISDN, LDIS T. 54 ACT
TALMADGE MEM. HOSP., AUGUSTA 30902

ELLISON, ROBERT G. 54 ACT TS
MED. CDLLEGE OF GEORGIA, AUGUSTA 30904

ENGLER, HARDLC S. 54 ACT SU
TALMADGE MEMDRIAL HDSPITAL, AUGUSTA 30902

ERKULVRAWATR, S. 54 ACT N
VA HOSP., AUGUSTA 30904

EVERETT, THEDDDRE 54 ACT L
1467 HARPER ST., AUGUSTA 30902

FAULKNER, ALVA A. 54 ACT OBG
1503 WINTER ST., AUGUSTA 30904

FELDMAN, DANIEL S. 54 ACT N
1120 15TH ST., AUGUSTA 30902

FELDMAN, ELAINE B. 54 ACT I
MED. CDLLEGE DF GA., AUGUSTA 30902

FISHBACK, MALCOLM E. 54 ACT TS
1467 HARPER ST., AUGUSTA 30902

FISHBEIN, SUMNER 54 ACT DPH
1467 HARPER ST., AUGUSTA 30902

FIVEASH, ARLIE E. 54 ACT R
1467 HARPER ST., AUGUSTA 30902

FLANAGIN, W. STEWART 54 ACT PL
1125 DRUID PARK AVE., AUGUSTA 30904

FORRESTER, EDWARD S., JR. 54 ACT OR
1515 PDPE AVE., AUGUSTA 30904

FRANK, MARTIN J. 54 ACT I
MED. CDLLEGE DF GA., AUGUSTA 30902

FREEDMAN, MURRAY A. 54 ACT DBG
1621 PENDLETDN RDAD, AUGUSTA 30904

FREEDMAN, SANDRA N. 54 ACT R
VA. HDSP., AUGUSTA 30904

FREEMAN, CHARLES 54 ACT OR
1515 PDPE AVE., AUGUSTA 30904

FULLER, WM. A. 54 ACT I
1403 GWINNETT ST., AUGUSTA 30902

GALLDWAY, RONALD FROST 54 ACT TS
1467 HARPER ST., AUGUSTA 30902

GAMMAL, T. A. EL 54 ACT NR
MED. CDLLEGE OF GA., AUGUSTA 30902

GARPISDN, ALTDN F. 54 ACT SU
808-13TH ST., AUGUSTA 30902

GARRISDN, GLEN E. 54 ACT C
MED. COLLEGE DF GA., AUGUSTA 30902

GARRISDN, JOSEPH MAYES 54 ACT ANES
812 13TH ST., AUGUSTA 30901

GILLESPIE, JDE I. 54 ACT ALR
1511 ANTHDNY RD., AUGUSTA 30904

GINDIN, R. ARTHUR 54 ACT NS
TALMADGE MEM. HOSP., AUGUSTA 30902

GLASSMAN, ARMAND B. 54 ACT PATH
MED. CDLLEGE OF GA., AUGUSTA 30902

GLOVER, D. H. G. 54 ACT PH
1001 BAILIE ST., AUGUSTA 30902

GODDWIN, HENRY N. 54 ACT OR
1521 ANTHDNY RD., AUGUSTA 30904

GDDDWIN, T. W. 54 DE1 SU
1 INDIAN CDVE, AUGUSTA 30904

GRAHAM, HAMLIN 54 ACT DR
1021 15TH ST., AUGUSTA 30901

GRAMLING, Z. W. 54 ACT ANES
TALMADGE MEM. HOSP., AUGUSTA 30902

GRAY, J. D. 54 DE5 I
J. DEWEY GRAY CIRCLE, AUGUSTA 30904

GREEN, ALFRED JOSEPH 54 ACT PD
1727 CENTRAL AVENUE, AUGUSTA 30904

GREENBLATT, ROBERT B. 54 ACT OBG
MEDICAL CDLLEGE DF GEDRGIA, AUGUSTA 30902

GRIFFIN, LDUIE H., JR. 54 ACT SU
1430 HARPER ST., AUGUSTA 30904

GULLEN, WARREN H. 54 ACT E
MED. COLLEGE OF GA., AUGUSTA 30902

HAAR, FLOYD L. 54 ACT NS
TALMADGE MEM. HDSP., AUGUSTA 30904

HAAS, MELVIN L. 54 ACT N
1003 CHAFEE AVE., AUGUSTA 30904

HANDY, JDHN R. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904

HARPER, HARRY T., JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

HARPER, HARRY T., III 54 ACT C
1467 HARPER ST., AUGUSTA 30902

HARPER, HERBERT S. 54 ACT PD
996 CAMPBLLTN RD., N. AUGUSTA, S. C. 29841

HARRELL, H. P. 54 DE1 PD
1011 MARSHALL AVE., N. AUGUSTA, SC 29841

HARRISDN, F. N. 54 ACT GBG
1021 15TH ST., AUGUSTA 30901

HARTLAGE, PATRICIA L. 54 ACT GR
MED. CDLLEGE DF GA., AUGUSTA 30902

HASTINGS, E. V. 54 ACT PATH
ST. JOSEPHS HOSPITAL, AUGUSTA 30904

HENSLEY, E. A. 54 DE1
GIBSDN 30810

HILTY, MILD D. 54 ACT PD
561 S. 17TH ST., CDLUMBUS, DHID 43205

HOGUE, WILLIAM L. 54 ACT R
TALMADGE HDSP., AUGUSTA 30904

HORSEMAN, RDBERT W. 54 ACT ANES
BDX 2842, AUGUSTA 30904

HDWINGTDN, JERRY W. 54 ACT R
UNIVERSITY HDSPITAL, AUGUSTA 30902

HUDSDN, JACK 54 ACT FP
SDUTHGATE PLAZA, AUGUSTA 30906

HUDSON, JAMES B. 54 ACT I
TALMADGE MEM. HDSP., AUGUSTA 30902

HUFF, THDMAS A. 54 ACT EN
MEDICAL CDLLEGE DF GA., AUGUSTA 30904

HUGHES, JDHN L. 54 ACT P
STEVENS CREEK RD.-F, MARTINEZ 30907

HULL, DAVID S. 54 ACT DPH
MEDICAL CDLLEGE OF GA., AUGUSTA 30904

HUMPHRIES, ARTHUR L., JR. 54 ACT SU
TALMADGE MEM. HDSP., AUGUSTA 30902

IHNEN, MENARD 54 ACT PATH
LAB., UNIVERSITY HDSPITAL, AUGUSTA 30902

JACKSDN, JAMES G. 54 ACT DR
1140 CRUID PARK AVE., AUGUSTA 30904

JEANS, PARK C., JR. 54 ACT GPH
1021 15TH ST., AUGUSTA 30902

JELENKO, CARL, III 54 ACT SU
TALMADGE MEM. HDSP., AUGUSTA 30902

JENNINGS, W. D., JR. 54 ACT SU
V. A. HDSPITAL, AUGUSTA 30904

JDHN, FARES 54 ACT PATH
MEDICAL CDLLEGE DF GA., AUGUSTA 30904

JOHNSDN, JIMPSEY B. 54 ACT R
MED. COLLEGE DF GEORGIA, AUGUSTA 30902

JOHNSDN, JULIUS T. 54 ACT P
1467 HARPER ST., F, AUGUSTA 30902

JOHNSDN, MARVIN E. 54 ACT PATH
1467 HARPER ST., AUGUSTA 30902

JONES, G. FRANK, JR. 54 ACT SU
2266 WRIGHTSBDRD RDAD, AUGUSTA 30904

JONES, KENNETH D. 54 ACT P
EXEC. PK. F, SUITE 526, MARTINEZ 30907

JDWERS, J. R. 54 ACT FP
210 DAK ST., MARTINEZ 30907

KANTO, WILLIAM P., JR. 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902

KAY, JAMES B., JR. 54 ACT U
1021 15TH ST., AUGUSTA 30901

KEENAN, JOSEPH P. 54 I&R
9 BICKFORD ST., SIMSBURY, CT 06070

KEISLER, DAVID L. 54 A
MEDICAL COLLEGE OF GA., AUGUSTA 30904

KELLY, GORDON M. 54 ACT SL
1467 HARPER ST., AUGUSTA 30902

KILPATRICK, ZACHARY M. 54 ACT GE
1467 HARPER ST., AUGUSTA 30902

KLEMANN, GILBERT 54 ACT I
1021 15TH ST., AUGUSTA 30901

KUSKE, TERRENCE T. 54 ACT I
MED COLLEGE OF GA., AUGUSTA 30904

LA MOTTE, IRENE F. 54 ACT
1500 JOHNS RD., AUGUSTA 30904

LASLIE, MICHAEL N. 54 ACT ANES
MCG, AUGUSTA 30902

LEE, BOTHWELL G. 54 I&R
BOX 717, MCG, AUGUSTA 30902

LEE, F. LANSING 54 ACT I
1433 GWINNETT ST., AUGUSTA 30902

LEE, JOSEPH D. 54 ACT SL
1021 15TH ST., AUGUSTA 30901

LEE, MOD HEE 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902

LEMON, ROMAN, JR. 54 ACT OBG
3651 WHEELER RD., AUGUSTA 30904

LEONARD, ROBERT 54 ACT CALR
1109 TELFAIR ST., AUGUSTA 30901

LEVY, JACK H. 54 ACT R
1425 GWINNETT ST., AUGUSTA 30902

LIEBELT, ROBERT A. 54 ACT ACM
N.W. OHIO UNIV. CLG-MED., KENT, OHIO 44240

LIN, TA-JUNG 54 ACT OBG
MEDICAL COLLEGE OF GA., AUGUSTA 30904

LINDER, CHARLES W. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902

LINDLEY, JACK B. 54 ACT SL
1430 HARPER ST., AUGUSTA 30902

LITTLE, ROBERT C. 54 ACT C
MED COLLEGE OF GA., AUGUSTA 30904

LIU, PAUL I. 54 ACT PATH
MED. COLLEGE OF GA., AUGUSTA 30902

LOGUE, H. EDWARD 54 DE2 FP
MED. COLLEGE OF GA., AUGUSTA 30902

LOTT, THOMAS M. 54 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520

LOTTERHOS, WILLIAM E. 54 ACT FP
MED. COLLEGE OF GA., AUGUSTA 30902

LUCAS, WILLIAM T. 54 ACT U
1276 MERRY ST., AUGUSTA 30904

LUXENBERG, MALCOLM N. 54 ACT OR
1120 15TH ST., AUGUSTA 30902

MAGRUDER, RICHARD L., JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

MAHONEY, PAUL D. 54 ACT ANES
3208 MONTPELIER DR., AUGUSTA 30904

MALONEY, GEORGE R. 54 ACT U
1467 HARPER ST., AUGUSTA 30902

MANGANIELLO, LOUIS O. J. 54 ACT NS
2247 WRIGHTSBORO RD., AUGUSTA 30902

MANSBERGER, ARLIE 54 ACT GE
MCG, DEPT. SURGERY, AUGUSTA 30902

MARKHAM, JOHN C., III 54 ACT GE
1514 ANTHONY RD., AUGUSTA 30904

MARSCHALK, F. F., JR. 54 ACT I
P. O. BOX 3803, AUGUSTA 30904

MARSHALL, LOUIE W. 54 ACT P
NO CURRENT ADDRESS

MARTIN, JOHN M. 54 ACT I
1138 DRUID PARK AVE., AUGUSTA 30904

MASSENGALE, L. R. 54 ACT PD
1903 ROCK SPRINGS DR., AUGUSTA 30904

MAYFIELD, GEORGE R. 54 ACT I
2247 WRIGHTSBORO RD., AUGUSTA 30904

MCCORD, JAMES W. 54 ACT N
1514 ANTHONY RD., AUGUSTA 30904

MCCRANIE, E. JAMES 54 ACT P
MEDICAL COLLEGE OF GA., AUGUSTA 30902

MCCRANIE, MARTHA S. 54 ACT P
TALMADGE MEM. HOSP., AUGUSTA 30902

MCDONALD, JAMES K. 54 ACT P
810 13TH ST., AUGUSTA 30902

MCDONOUGH, PAUL G. 54 ACT OBG
TALMADGE MEM. HOSP., AUGUSTA 30902

MCFARLAND, D. EDWARD 54 ACT PATH
UNIV. HOSP., WALTON WAY, AUGUSTA 30904

MCGAHEE, ROBERT C. 54 ACT PD
1429 GWINNETT ST., AUGUSTA 30902

MCGARITY, S. S., JR. 54 ACT P
1423 HARPER ST., AUGUSTA 30904

MCINNES, GEORGE F. 54 ACT PL
P.O. BOX 1668, WILMINGTON, DEL. 19899

MCKNIGHT, ROBERT R. 54 ACT OR
1417 GWINNETT ST., AUGUSTA 30902

MCNAMARA, VIRGINIA P. 54 ACT OBG
MEDICAL COLL. OF GA., AUGUSTA 30902

MCRAE, O. R., JR. 54 ACT SL
1427 GWINNETT ST., AUGUSTA 30902

MEALING, H. G. 54 DE5 I
301 SOUTHERN FINANCE BLDG., AUGUSTA 30902

MEEKS, WILLIAM H. 54 ACT NS
1140 DRUID PARKS AVE., AUGUSTA 30902

MEYER, BERNARD C. 54 ST
NO CURRENT ADDRESS

MILLER, ABRAHAM 54 ACT OBG
1270 MERRY STREET, AUGUSTA 30904

MITCHELL, CHARLES H. 54 R ANES
MEDICAL COLLEGE OF GA., AUGUSTA 30902

MITCHENER, J. W. 54 ACT PATH
UNIVERSITY HOSP., AUGUSTA 30902

MOORE, VICTOR AUGUSTUS 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

MOORE, WILLIAM L. 54 ACT I
VA HOSP., F-D-H, AUGUSTA 30904

MOORES, RUSSELL R. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902

MORETZ, WILLIAM H. 54 ACT SU
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902

MORGAN, MARY E. 54 ACT I
VA HOSPITAL, AUGUSTA 30904

MOSS, BENJAMIN F., JR. 54 ACT PN
UNIVERSITY HOSPITAL, AUGUSTA 30902

MULHERIN, C. S. 54 ACT SU
1527 GWINNETT ST., AUGUSTA 30904

MULHERIN, JOSEPH L. 54 ACT SU
1467 HARPER ST., AUGUSTA 30902

MULLINS, WM. BERNARD 54 ACT PATH
1467 HARPER ST., AUGUSTA 30902

MURPHEY, ALEX T. 54 ACT I
1134 DRUID PARK AVENUE, AUGUSTA 30904

MURPHY, MICHAEL J. 54 ACT OPH
1502 ANTHONY RD., AUGUSTA 30904

MURPHY, WILLIAM R. 54 ACT PATH
622 MAGNOLIA, S. E., AIKEN, S. C. 29801

MUSHET, G. R. 54 ACT N
1003 CHAFEE AVE., AUGUSTA 30901

NELSON, GEORGE H. 54 ACT OBG
MED. COLLEGE OF GA., AUGUSTA 30902

NELSON, MAYNARD 54 ACT SU
1502 ANTHONY RD., AUGUSTA 30904

NESBITT, ROBERT R., JR. 54 ACT SL
MED. COLLEGE OF GA, AUGUSTA 30902

NICHOLS, POMEROY 54 ACT NS
1521 POPE AVE., AUGUSTA 30904

NIXON, DANIEL W. 54 ACT GN
MEDICAL COLLEGE OF GA., AUGUSTA 30904

OLDHAM, HARRY M., JR. 54 ACT OBG
1501 ANTHONY RD., AUGUSTA 30904

OLLER, JOSEPH L. 54 ACT ANES
812 13TH ST., AUGUSTA 30901

OQUINN, JAMES L. 54 ACT PATH
3651 WHEELER RD, AUGUSTA 30904

OREAR, HARRY B. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

OSBORNE, HORACE H. 54 ACT ANES
3609 NASSAU DR., AUGUSTA 30904

OTKEN, LUTHER B., JR. 54 ACT PATH
TALMADGE MEM. HOSP., AUGUSTA 30902

OWEN, RALPH G. 54 ACT OBG
1502 ANTHONY RD., AUGUSTA 30904

OWINGS, RICHARD S. 54 ACT PD
1467 HARPER ST., AUGUSTA 30902

PALMER, JOHN R. 54 ACT DR
MED. COLLEGE OF GA., AUGUSTA 30904

PARRISH, ROBERT A., JR. 54 ACT SL
TALMADGE MEM. HOSP., AUGUSTA 30902

PATTON, MAURICE G. 54 ACT PH
1001 BAILIE DR., AUGUSTA 30902

PAYNE, R. F. 54 ACT PH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

PERKINS, H. R. 54 DE1 OALR
P. O. BOX 3583, AUGUSTA 30904

PERSALL, JOHN T. 54 ACT OBG
1507 ANTHONY RD., AUGUSTA 30904

PESKIN, HERMAN 54 ACT I
1134 DRUID PARK AVE., AUGUSTA 30904

PESSOLANO, L. C. 54 ACT FP
2307 MARVIN PLACE, AUGUSTA 30906

PHINIZY, JOHN 54 ACT I
3651 WHEELER RD., AUGUSTA 30904

PHINIZY, IRVINE 54 DE5 I
SOU. FINANCE BLDG., AUGUSTA 30902

PINSON, HARRY D. 54 ACT SU
1467 HARPER ST., AUGUSTA 30902

POOL, WINFORD H., JR. 54 ACT R
TALMADGE MEM. HOSP., AUGUSTA 30902

POWELL, BARBARA A. 54 ACT OBG
MEDICAL VILLAGE, AUGUSTA 30904

PRATHER, STUART H., JR. 54 ACT R
3623 J. DEWEY GRAY CIRCLE, AUGUSTA 30904

PRYOR, CAROL G. 54 ACT OBG
1500 JOHNS RD., AUGUSTA 30904

PUND, EDGAR R. 54 DE5 PATH
ROUTE 4, SENECA, S.C. 29678

PURSLEY, NORMAN B. 54 ACT
GA. TRAINING SCHOOL, GRACEWOOD 30812

QUANTZ, NEWTON G., JR. 54 ACT OTC
2283 WRIGHTSBORO RD., AUGUSTA 30904

QUILLIAN, WILLARD E., III 54 ACT P
MED. COLLEGE OF GA., AUGUSTA 30902

RAO, P. S. 54 ACT PDC
MEDICAL COLLEGE OF GA., AUGUSTA 30902

RAO, R. N. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902

REEVES, NATHAN 54 ACT I
2264 WRIGHTSBORO RD., AUGUSTA 30904

REYNOLDS, JOHN D. III 54 ACT NS
1521 POPE AVE., AUGUSTA 30904

RHODE, CHARLES MARTIN 54 ACT SU
VA HOSPITAL, AUGUSTA 30904

RINKER, J. ROBERT 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ROBERTSON, ALEX F. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902

ROULE, J. VICTOR 54 DE1 OALR
2251 CUMMING RD., AUGUSTA 30904

RUBIN, JOSEPH W. 54 ACT TS
MCG, AUGUSTA 30902

RUCKER, J. T., JR. 54 ACT ANES
812 13TH ST., AUGUSTA 30901

SANDERS, CONRAD W., JR. 54 ACT SU
MED. COLL OF GA., AUGUSTA 30902

SANDERS, RUTH J. 54 ACT R
1021 15TH ST., AUGUSTA 30904

SAUNDERS, ELWYN A. 54 ACT OR
MEDICAL COLLEGE OF GA., AUGUSTA 30902

SCHARFF, LOUIS, III 54 ACT PD
GRACEWOOD HOSPITAL, GRACEWOOD 30812

SCHILLING, ROBINSON W. JR 54 ACT OTC
2282 WRIGHTSBORO RD., AUGUSTA 30904

SCOGGIN, W. A. 54 ACT OBG
TALMADGE MEM. HOSP., AUGUSTA 30902

SCOGGINS, HENRY O. 54 ACT OBG
1501 ANTHONY RD., AUGUSTA 30904

SEARCY, ASHBURN P. 54 ACT ANES
P. O. BOX 2820, ALGUSTA 30904

SELL, M. B., JR. 54 ACT P
MEDICAL COLLEGE OF GA., AUGUSTA 30904

SHARMA, KAILASH B. 54 ACT PATH
UNIV. HOSP., AUGUSTA 30902

SHEPEARD, WALTER L. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902

SHEPHERD, MASON H. 54 ACT SU
1430 HARPER ST., AUGUSTA 30902

SHERMAN, HARRY C. 54 ACT SU
3010 SUSSEX DR., AUGUSTA 30904

SHIVER, CHARLES B. 54 ACT
806-13TH ST., AUGUSTA 30901

SHORT, OWIGHT H., II 54 A SU
MED. COLL OF GA., AUGUSTA 30902

SINGLETARY, ELIZABETH A. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30904

SKEEL, DAVID A. 54 ACT U
MCG., AUGUSTA 30902

SMITH, C. C. 54 ACT D
1349 DRUID PARK AVENUE, AUGUSTA 30904

SMITH, DOUGLAS L. 54 I&R
MEDICAL COLLEGE OF GA., AUGUSTA 30904

SMITH, EDWARD H., JR. 54 ACT D
1021 15TH ST., AUGUSTA 30901

SMITH, J. GRAHAM 54 ACT O
MED. COLLEGE OF GA., AUGUSTA 30902

SMITH, R. LOUIE 54 ACT I
1514 ANTHONY RD., AUGUSTA 30904

SPEARS, ROBERT S. 54 ACT ANES
809 KAMEL CIRCLE, AUGUSTA 30904

STEED, WILLIAM A. 54 ACT OALR
1122 DRUID PARK AVE., AUGUSTA 30904

STILL, JOSEPH M., JR. 54 ACT PL
MCG, AUGUSTA 30902

STOCKS, S. ALLAN 54 ACT OPH
1514 ANTHONY RD., AUGUSTA 30904

STODDARD, LELAND D. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902

STORY, FRANK C., JR. 54 ACT OBG
1505 WINTER ST., AUGUSTA 30904

STRETCHER, GEORGE S. 54 ACT D
MCG, AUGUSTA 30902

STRONG, WILLIAM B. 54 ACT PDC
MED. COLLEGE OF GA., AUGUSTA 30904

SULLIVAN, DANIEL B. 54 ACT SL
30 HARPER ST., AUGUSTA 30902

SUMMERS, GERALD R. 54 ACT R
RT. 1, BOX 170, THOMSON 30824

SUSSMAN, HY C. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

SWIFT, THOMAS R. 54 ACT N
MCG, DEPT NEU., AUGUSTA 30902

TALLEDO, O. EDUARDO 54 ACT OBG
MED COLLEGE OF GA., AUGUSTA 30904

TANENBAUM, JULIAN B. 54 ACT PD
2315 CENTRAL AVE., AUGUSTA 30904

THIGPEN, CORBETT H. 54 ACT P
1423 HARPER ST., AUGUSTA 30902

THOMAS, DAVID R., JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902

THOMAS, LUTHER M., JR. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904

THOMAS, R. P. 54 ACT OPH
1445 HARPER ST., AUGUSTA 30902

THORNTON, NANCY 54 ACT PD
VA HOSP., AUGUSTA 30904

THREEFOOT, SAM A. 54 ACT I
VA HOSP., AUGUSTA 30904

THURMOND, A. G. 54 ACT OBG
524 GEORGIA AVE., N. AUGUSTA, S. C. 29841

THURMOND, GEORGE W. 54 ACT GTD
2283 WRIGHTSBORO RD., AUGUSTA 30904

THURMOND, J. W. 54 DES OBG
1167 UNIVERSITY PL., AUGUSTA 30902

TILLERY, WM. V., III 54 ACT OPH
1514 ANTHONY RD., AUGUSTA 30904

TORPIN, RICHARD 54 DES OBG
2618 WALTON WAY, AUGUSTA 30904

VANDERZALM, THEODORA 54 ACT R
VA HOSP., FOREST HILL DIV., AUGUSTA 30902

VAN GIESEN, GEO. E., JR. 54 ACT I
3623 DEWEY GRAY CIR., AUGUSTA 30904

VOLPITTO, P. P. 54 ACT ANES
TALMADGE MEM. HOSP., AUGUSTA 30902

WALTERS, GORDON E. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904

WARD, DANIEL F. 54 ACT P
1467 HARPER ST., AUGUSTA 30902

WATERS, A. J. 54 ACT ANES
3405 SASANQUA DR., AUGUSTA 30904

WATSON, W. G. 54 ACT OBG
1167 UNIVERSITY PL., AUGUSTA 30902

WEBSTER, PAUL O., III 54 ACT GE
MED. COLLEGE OF GEORGIA, AUGUSTA 30904

WEEKS, RICHARD B. 54 DES SL
4230 13TH ST., ST. SIMONS ISLAND 31522

WEIHE, JAMES F. 54 I&R
MEDICAL COLLEGE OF GA., AUGUSTA 30902

WELTER, DONALD J. 54 ACT FP
1101 15TH ST., AUGUSTA 30901

WESTON, PAUL D. 54 ACT SU
1235 GWINNETT ST., AUGUSTA 30901

WHELCHEL, MERRITT C. 54 ACT OPH
905 15TH ST., SUITE E, AUGUSTA 30902

WILOS, P. L. 54 ACT OBG
MEDICAL COLLEGE OF GA., AUGUSTA 30904

WILKES, W. A. 54 ACT PD
1203 HIGHLAND AVE., AUGUSTA 30904

WILLIAMS, DAVID C., JR. 54 ACT L
1142 DRUID PARK, AUGUSTA 30904

WILLIAMS, GEORGE P. 54 ACT OBG
1505 WINTER ST., AUGUSTA 30904

WILLIAMS, JACK B. 54 ACT ANES
812 13TH ST., AUGUSTA 30901

WILLIAMS, JOHN L. 54 ACT NS
1521 POPE AVE., AUGUSTA 30904

WITHAM, A. CALHOUN 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

WITHERINGTON, ROY 54 ACT L
MED COLLEGE OF GA., AUGUSTA 30902

WOMBLE, J. G. 54 ACT SL
1256 MERRY ST., AUGUSTA 30904

WRAY, BETTY B. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902

WRAY, CHARLES H. 54 ACT SL
TALMADGE MEM. HOSP., AUGUSTA 30902

WRIGHT, CLAUDE STARR 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

WRIGHT, GEO. W. 54 DES SU
2913 BRANSFORD RD., AUGUSTA 30904

WYLIE, M. H. 54 ACT SU
1403 GWINNETT ST., AUGUSTA 30902

55—SCREVEN

FREEMAN, JAMES C. 55 ACT FP
SYLVANIA 30467

HAWKINS, KATRINE RAWLS 55 ACT FP
P. O. BOX 518, SYLVANIA 30467

HOGSETTE, GERALD B. 55 ACT SL
SYLVANIA 30467

KENT, WILLIAM R. 55 ACT FP
P. O. BOX 218, SYLVANIA 30467

SIMMONS, WILLIAM G. 55 ACT FP
SYLVANIA 30467

56—SOUTH GEORGIA (Berrien, Clinch, Cook, Echols, Lanier, Lowndes)

ACREE, RUSSELL A. 56 ACT FP
HAHIRA 31632

AGUERO, OSCAR E. 56 ACT DR
DOCTORS BLDG., VALDOSTA 31601

ALFONSO, JOSE G. 56 ACT PD
310 JANET ST., VALDOSTA 31601

AUSTIN, G. J., JR. 56 ACT PD
DOCTORS BLDG., VALDOSTA 31603

BARTON, DEWEY L. 56 ACT R
DOCTORS BLDG., VALDOSTA 31603

BEALL, AVERY P. 56 ACT FP
P. O. BOX 129, ADEL 31620

BECHTEL, H. BERNARD 56 ACT D
2101 N. PATTERSON ST., VALDOSTA 31603

BENNETT, VAN B. 56 ACT I
RT. 1, BOX 2, VALDOSTA 31601

BRANCH, DAVID L., JR. 56 ACT OR
DOCTORS BLDG., VALDOSTA 31603

BRANNEN, J. H. 56 ACT U
401 WOODROW WILSON DR., VALDOSTA 31603

BROWNSBERGER, JOHN F. 56 DES SL
LAKELAND 31635

BURNS, O. L. 56 DES FP
P.O. BOX 189, LAKE PARK 31636

CAMPA, JOSE C. 56 ACT OR
1807 JERRY JOHNS DR., VALDOSTA 31601

CARTER, YANCEY F. 56 ACT FP
1223 E. MCPHERSON, NASHVILLE 31639

CHISHOLM, LEWIS F. 56 ACT FP
ROBBINS CLINIC, HOMERVILLE 31634

CLEMENTS, FRED N. 56 ACT FP
ADEL 31620

CREECH, EARL L. 56 ACT OR
P. O. BOX 2261, VALDOSTA 31601

DAVIS, BYRON S. 56 ACT PATH
P. O. BOX 2564, VALDOSTA 31601

DICKSON, WILLIAM A. 56 ACT FP
408 E. STANFILL, HAHIRA 31632

DISMUKE, JAMES C. 56 ACT FP
P. O. BOX 409, ADEL 31620

DRURY, WILEY L. 56 ACT ANES
P.O. BOX 1727, VALDOSTA 31601

ELDRIDGE, F. G. 56 ACT R
DOCTORS BLDG., VALDOSTA 31603

GEE, W. N., JR. 56 ACT I
401 E. JANE ST., VALDOSTA 31601

GIDDENS, I. S. 56 ACT FP
LAKELAND 31635

GREER, MACK V. 56 ACT FP
P. O. BOX 146, HOMERVILLE 31634

HATCH, JOSEPH C. 56 ACT SL
ADEL 31620

HOBBY, CHARLES F. 56 ACT R
104 DOCTORS BLDG., VALDOSTA 31603

HODGES, CHAS. A., JR. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31601

HOLT, EDWARD 56 ACT FP
807 N. PARRISH AVE., ADEL 31620

HOUSTON, JOSEPH S. 56 ACT P
305 EMORY ST., VALDOSTA 31603

JOHNSON, A. M. 56 ACT PD
DOCTORS BLDG., VALDOSTA 31603

LAWSON, QUENTIN T. 56 ACT U
401 WOODROW WILSON DR., VALDOSTA 31601

LITTLE, ALEX G., JR. 56 ACT SL
RT. 1, BOX 4, VALDOSTA 31601

MARTINEZ, MARCIAL E. 56 ACT R
P. O. BOX 303, ADEL 31620

MATHIS, JAMES W. 56 ACT SL
209 PENDLETON DR., VALDOSTA 31601

MEADORS, JASON LAWRENCE 56 ACT R
P. O. BOX 2254, VALDOSTA 31601

MILLER, J. M. 56 ACT OBG
2307 N. PATTERSON ST., VALDOSTA 31603

MIXSON, E. HARRY 56 ACT
DOCTORS BLDG., VALDOSTA 31603

MIXSON, JOYCE F., JR. 56 ACT OBG
105 DOCTORS BUILDING, VALDOSTA 31603

MOSELEY, THOMAS H. 56 ACT OBG
DOCTORS BLDG., VALDOSTA 31603

MOYE, BEN H. 56 ACT OPH
3024 N. PATTERSON ST., VALDOSTA 31601

NATION, THOMAS C. 56 ACT PATH
DOCTORS BLDG., VALDOSTA 31601

NELSON, FRED L., JR. 56 ACT R
NASHVILLE, GA. 31639

NEWLIN, LUCIAN K. 56 ACT
307 E. JANE ST., VALDOSTA 31601

NUTT, RICHARD L. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31603

OTEIZA, JORGE A. 56 ACT FP
2008 WIMBLETON DR., THOMASVILLE 31792

OWENS, B. G. 56 DES SL
111 E. ALDEN AVE., VALDOSTA 31603

PARKHURST, ROBERT D. 56 ACT PD
107 WOODROW WILSON, VALDOSTA 31601

PARROTT, JESSE LYLE 56 ACT FP
HAHIRA 31632

PETERS, JAMES S. 56 ACT R
4513 CLUB CIR., N.E., ATLANTA 30319

QUATTLEBAUM, ROBERT B. 56 ACT R
P. O. BOX 1727, VALDOSTA 31601

RETTERBUSH, W. C. 56 ACT SL
BOX 2313, VALDOSTA 31603

RODRIGUEZ, HUMBERTO 56 ACT SL
P. O. BOX 2274, VALDOSTA 31601

SAUNDERS, A. F. 56 DES OBG
P. O. BOX 2035, VALDOSTA 31603

SHERMAN, HENRY T. 56 ACT I
P.O. BOX 1409, VALDOSTA 31601

SMITH, FRANK Q. 56 ACT OBG
P. O. BOX 2748, VALDOSTA 31601

SMITH, FRED C. 56 ACT SL
DOCTORS BLDG., VALDOSTA 31603

SMITH, HENRY BRIGGS 56 ACT ALR
DOCTORS BLDG., VALDOSTA 31603

SMITH, T. H. 56 DES OALR
3024 N. PATTERSON ST., VALDOSTA 31603

SMITH, THOS. H., JR. 56 ACT OPH
3024 N. PATTERSON ST., VALDOSTA 31601

STECKER, DONALD C. 56 ACT
LOUIS SMITH MEM. HOSP., LAKELAND 31635

STUBBS, JOE C. 56 ACT I
101 NORTHSIDE DR., VALDOSTA 31601

STUMP, ROBERT L., JR. 56 ACT FP
1624 BODNE DR., VALDOSTA 31603

THOMPSON, E. F. 56 DES OALR
DOCTORS BUILDING, VALDOSTA 31603

THOMPSON, EMORY F. 56 ACT OALR
DOCTORS BUILDING, VALDOSTA 31603

THRELKELD, WILLIAM A. 56 ACT P
P. O. BOX 1727, VALDOSTA 31603

TOVAR-DE-HOYOS, MANUEL 56 ACT FP
2311 N. PATTERSON ST., VALDOSTA 31601

TRAMBLIE, WILLIAM G. 56 ACT SL
116 HOSPITAL DR., LAKELAND 31635

WADE, V. C. 56 ACT
104-C COUNTRY CLUB DR., AMERICUS 31709

WINSTON, R. K. 56 ACT OPH
DOCTORS BLDG., VALDOSTA 31603

YEAGER, OTIS WAYNE 56 ACT PD
P. O. BOX 2127, VALDOSTA 31603

YOULES, OWEN K., JR. 56 ACT OBG
DOCTORS BLDG., VALDOSTA 31603

57—SOUTHEAST GEORGIA
(Montgomery, Tattnall, Toombs, Treutlen, Wheeler)

BARFIELD, JAMES E. 57 ACT
300 ARLINGTON DR., VIDALIA 30474

BEDINGFIELD, W. H. 57 ACT FP
P. O. BOX 629, VIDALIA 30474

CONNER, H. I. 57 ACT SL
P. O. BOX 1107, VIDALIA 30474

DARBY, V. L. 57 DES SL
706 CHURCH ST., VIDALIA 30474

DRAKE, CHAS. F. 57 ACT FP
121 N. CASWELL, GLENNVILLE 30427

GORDON, JAMES H. 57 S PH
TOOMBS COUNTY HEALTH DEPT., LYONS 30436

JELKS, LOUIS R. 57 ACT SL
P. O. BOX 128, REIDSVILLE 30453

MCARTHUR, JOHN D. 57 ACT
LYONS 30436

MCNAIR, WILLIAM P. 57 ACT FP
SOPERTON 30457

MCRAE, L. C. 57 ACT FP
P. O. BOX 216, MT. VERNON 30445

MERRITT, GEORGE W. 57 ACT FP
300 ARLINGTON DR., VIDALIA 30474

WHITTLE, MICHAEL H. 57 DE4 FP
673 MED. DET., APO SAN FRANCISCO, CA 96332

YATES, A. J., JR. 57 ACT FP
SOPERTON 30457

58—SOUTHWEST GEORGIA
(Calhoun, Clay, Early, Miller, Quitman)

CHEN, ER-WEI 58 ACT FP
DRS. MEDICAL CENTER, EDISON 31746

CROWDIS, JAS. HUDSON, JR. 58 ACT
BLAKELY 31723

GILES, EUGENE H. 58 ACT FP
322 S. MAIN ST., BLAKELY 31723

JENNINGS, ROBERT E. 58 ACT
ARLINGTON CITY HOSPITAL, ARLINGTON 31713

LASSITER, HOMER L. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713

MERRITT, HINTON J. 58 ACT FP
COLQUITT 31737

MERRITT, JAMES W. 58 ACT FP
COLQUITT 31737

MONTES, ISMAEL G. 58 ACT SL
1605 SHOTWELL ST., BAINBRIDGE 31717

RENTZ, TURNER W. 58 ACT FP
COLQUITT 31737

WETHERBY, DAVID 58 ACT
FT. GAINES 31751

WOOD, HOMER P. 58 ACT FP
CLAY COUNTY HOSPITAL, FORT GAINES 31751

59—SPALDING
(Butts, Henry, Lamar)

ALONSO, JORGE P. 59 ACT ANES
604 S. 8TH ST., GRIFFIN 30223

AUSTIN, J. L. 59 ACT OALR
610 S. 8TH ST., GRIFFIN 30223

BLACK, GRADY E. 59 ACT PD
567 S. 9TH ST., GRIFFIN 30223

BLANCHARD, HUBERT H. 59 ACT P
720 HOLMES ST., BARNESVILLE 30204

BLISSIT, JOSEPH A. 59 ACT I
169 DECATUR ROAD, MCDONOUGH 30253

BRANDON, R. V. 59 DE1 FP
WESTBURY MED CARE HOME, JENKINSBURG 30234

BROWN, GEORGE W. 59 ACT R
686 S. 8TH STREET, GRIFFIN 30223

BUNYASARANAND, PRICHA 59 ACT D
610 S. 8TH ST., GRIFFIN 30223

CASWELL, ROBERT J., II 59 ACT R
686 S. 8TH ST., GRIFFIN 30223

CLOUSE, JOHN E., JR. 59 ACT FP
682 S. 8TH ST., GRIFFIN 30223

COOPER, FLOYD C., III 59 ACT P
ROUTE 4, BOX 309, GRIFFIN 30223

COPELAND, H. J. 59 DE1 SL
615 E. COLLEGE ST., GRIFFIN 30223

CRAWFORD, JOHN B. 59 ACT FP
BARNESVILLE 30204

DUKE, GRADY F. 59 ACT SL
303 SOUTH 8TH ST., GRIFFIN 30223

DUNAWAY, JAMES BOYD 59 ACT PD
712 S. 8TH STREET, GRIFFIN 30223

FLOYD, T. J., JR. 59 ACT SL
506 S. 8TH ST., GRIFFIN 30223

FOSTER, GURDON R., JR. 59 ACT FP
MCDONOUGH 30253

FOSTER, HENRY A. 59 ACT
319 S. 9TH ST., GRIFFIN 30223

GRAYSON, JOHN T. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223

HAJOSY, RALPH W. 59 ACT OR
815 S. 8TH ST., GRIFFIN 30223

HALL, JESSE DENNY, JR. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223

HENRY, GEORGE T. 59 ACT FP
BARNESVILLE 30204

HUNT, THOMAS JEFFERSON 59 ACT SL
610 S. 8TH ST., GRIFFIN 30223

JACKSON, J. H. 59 DES FP
10 MARKET ST., BARNESVILLE 30204

JONES, A. P. 59 ACT FP
P.O. BOX 741, GRIFFIN 30223

KELLEY, J. WELDON 59 ACT SL
602 S. 8TH ST., GRIFFIN 30223

KING, JOHN LAMAR 59 ACT U
8TH STREET, GRIFFIN 30223

KING, WM. R., JR. 59 ACT SL
708 S. 8TH STREET, GRIFFIN 30223

KREPPS, ARTHUR C., II 59 ACT OBG
503 S. 8TH ST., GRIFFIN 30223

LANDHAM, JACKSON W., JR. 59 ACT I
743 S. 8TH ST., GRIFFIN 30223

LESCHER, CHARLES F. 59 S R
14627 S.W. 63RD CT., MIAMI, FLA. 33158

MACIAS, F. M. 59 ACT ANES
24 MAIN ST., HAMPTON 30228

MONTERO, ENRIQUE 59 ACT ANES
546 S. 8TH ST., GRIFFIN 30223

OSHLAG, ABRAHAM M. 59 ACT I
3175 HILL STREET, GRIFFIN 30223

RELEFORD, CHARLES C. 59 ACT
218 W. BROAD ST., GRIFFIN 30223

REYNOLDS, KENNETH H. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223

SKINNER, JAMES M. 59 ACT DBG
610 SOUTH EIGHTH STREET, GRIFFIN 30223

SMAHA, T. G. 59 ACT G
600 SOUTH 8TH STREET, GRIFFIN 30223

SMITH, WILLIAM V. 59 ACT OBG
503 S. 8TH ST., GRIFFIN 30223

STUCKEY, ANN D. 59 ACT PD
317 1/2 S. HILL STREET, GRIFFIN 30223

TAKLE, LEIV M. 59 ACT OPH
646 S. 8TH ST., GRIFFIN 30223

TATUM, L. L., JR. 59 ACT U
653 S. 8TH ST., GRIFFIN 30223

TRAYLOR, S. B. 59 ACT FP
BARNESVILLE 30204

WALKER, GED. L. 59 R
709 MAPLE DR., GRIFFIN 30223

WILLIAMS, VIRGIL B. 59 ACT SU
571 SOUTH 9TH STREET, GRIFFIN 30223

ZEVALLOS, CARLOS A. 59 ACT
SPALDING CTY HOSP., GRIFFIN 30223

60—STEPHENS-RABUN

AYERS, C. L. 60 OE5 FP
TOCCOA 30577

CONDLEY, KENNETH 60 ACT PD
304 N. SAGE, TOCCOA 30577

COPELAN, ELTON L. 60 ACT OBG
TOCCOA CLINIC, TOCCOA 30577

DOSS, MELVIN C. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577

FLYNN, THOMAS F. 60 OE4 SU
U. S. PHS. HOSP. 6500, NORFOLK, VA. 23508

FOWLER, JOHN E. 60 ACT FP
P. O. BOX 825, CLAYTON 30525

GILBERT, CLYDE O. 60 ACT OBG
800 E. DOYLE ST., TOCCOA 30577

GRAVES, EDWARD M. 60 ACT
MEDICAL ARTS BLDG., TOCCOA 30577

HAY, S. H. 60 ACT I
TOCCOA 30577

HELLENGA, IRVING D. 60 ACT FP
TOCCOA CLINIC, TOCCOA 30577

KING, GEORGE C. 60 ACT FP
BOX 307, CLAYTON 30525

KNOWLTON, JAMES W. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577

LAMPROS, C. PETER 60 ACT R
800 DOYLE ST., TOCCOA 30577

LAWRENCE, JOHN C. 60 ACT PD
800 E. DOYLE ST., TOCCOA 30577

LEE, FRED M. 60 ACT U
800 E. DOYLE ST., TOCCOA 30577

MCNEELY, HENRY H. 60 ACT FP
TOCCOA 30577

PAULY, ROBERT P. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577

PICKENS, JAMES C. 60 ACT OBG
800 E DOYLE ST., TOCCOA 30577

PITTARD, M. D. 60 ACT FP
TOCCOA 30577

SCHAEFER, W. B. 60 OE1 SU
930 18TH AVE. S., NAPLES, FLA 33940

SETZER, EDWARD H. 60 ACT I
800 E. DOYLE ST., TOCCOA 30577

SINGER, ARTHUR G. 60 ACT R
TOCCOA 30577

SLATE, ROBERT W. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577

THOMPSON, ROBERT E. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577

VEVERKA, FRANK 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577

WEBSTER, BRUCE S. 60 ACT EM
RT. 3, BOX 395-A, TOCCOA 30577

61—SUMTER
(Marion, Schley, Taylor, Webster)

ANDERSON, W. R. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709

ASTON, JAMES K. 61 ACT R
712 FORSYTH ST., AMERICUS 31709

COLLINS, ROBERT A. 61 ACT SU
212 REESE ST., AMERICUS 31709

DUDLEY, A. G. 61 OE4 OBG
205 S. LEE ST., AMERICUS 31709

DUDLEY, JAMES C. 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709

DURHAM, BON M. 61 OE3 I
142 S. JACKSON ST., AMERICUS 31709

FINKLEA, JOHN L. 61 OE2 FP
NO CURRENT ADDRESS

GATEWOOD, T. SCHLEY 61 ACT OBG
205 SOUTH LEE STREET, AMERICUS 31709

HERRON, JAMES G. 61 ACT I
1102 E. LAMAR AVE., AMERICUS 31709

KEULS, HANS A. 61 ACT OBG
1102 E. LAMAR ST., AMERICUS 31709

MONTGOMERY, R. C., II 61 ACT
BUTLER 31006

ROBERTS, SAVA M. 61 ACT R
P. O. BOX 621, AMERICUS 31709

ROBINSON, JOHN H., III 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709

RUNOLE, T. J. 61 ACT OPH
P.O. BOX 1026, AMERICUS 31709

SAMARA, DAVID J. 61 ACT U
1102 E. LAMAR ST., AMERICUS 31709

SAMS, FRANK H. 61 OE1 FP
REYNOLDS 31076

SAMS, FRANK H., JR. 61 ACT FP
BOX 536, REYNOLDS 31076

SANKARAN, K. N. V. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709

SAVAGE, C. P. 61 OE5 FP
MONTEZUMA 31063

SIMPSON, HARVEY L. 61 ACT SU
1102 LAMAR ST., AMERICUS 31709

SNEAD, JOSEPH A. 61 ACT DR
1102 E. LAMAR ST., AMERICUS 31709

TAN, HO T. 61 ACT ANES
AMERICUS & SUMTER CO HOSP., AMERICUS 31709

THOMAS, RUSSELL 61 OE1
131 SOUTH JACKSON STREET, AMERICUS 31709

THOMPSON, F. H. 61 ACT PATH
AMERICUS 31709

WALDEMAYER, E. W. 61 ACT FP
629 E. FORSYTH ST., AMERICUS 31709

WALL, BITHEL 61 ACT L
1105 FETNER DR., AMERICUS 31709

WHATLEY, E. C. 61 ACT
REYNOLDS 31076

WILSON, FRANK A., III 61 ACT I
LESLIE 31764

62—ST. JOHN'S PARISH
(Liberty)

BAUTISTA, GRACE C. 62 ACT PD
P.O. BOX 406 FRASER DR., HINESVILLE 31313

BAUTISTA, VICTOR C. 62 ACT ANES
LIBERTY MEMORIAL HOSP., HINESVILLE 31313

FRASER, WHITMAN 62 ACT FP
FRASER DRIVE, HINESVILLE 31313

ROBBINS, FRANK T. 62 ACT FP
513 OGLETHORPE BLVD., HINESVILLE 31313

SHIH, CHEN-WEN 62 ACT OBG
P.O. BOX 406, HINESVILLE 31313

SILAN, J. RUBEN O. 62 ACT SU
P. O. BOX 406, FRASER DR.,HINESVILLE 31313

64—TELFAIR

LABARBERA, ROBERT R. 64 ACT FP
PO BOX 98, HITCHCOCK HOSP., STRATTON 69043

MANN, FRANK R., JR. 64 ACT
MCRAE 31055

MCRAE, O. B. 64 ACT SU
MCRAE 31055

SMITH, F. A., JR. 64 ACT FP
MCRAE 31055

65—THOMAS AREA
(Brooks, Grady, Thomas)

ARNETT, THOMAS E. 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792

BELL, RUDOLPH 65 OE5 U
P.O. BOX 1675, THOMASVILLE 31792

BENTLEY, ALONZO J. 65 ACT OALR
918 S. BROAD ST., THOMASVILLE 31792

BOSWELL, W. C. 65 OE5 PD
P.O. BOX 1378, THOMASVILLE 31792

BRINSON, JOHN B., JR. 65 ACT FP
808 GORDON AVE., THOMASVILLE 31792

CAIN, ROBERT T. 65 ACT FP
P.O. BOX 231, QUITMAN 31643

CARICO, JAMES M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

CHENEY, HUDDIE L. 65 ACT I
P.O. BOX 1099, THOMASVILLE 31792

CHRISTENSEN, EUNICE H. 65 R ANES
J. D. ARCHBOLD HOSP., THOMASVILLE 31792

CHRISTENSEN, EVERETT O. 65 ACT FP
J. D. ARCHBOLD HOSP., THOMASVILLE 31792

COURSON, HERMAN C. 65 ACT I
P. O. BOX 1939, THOMASVILLE 31792

DUNAWAY, MARSHALL C. 65 ACT I
900 GORDON AVE., THOMASVILLE 31792

FALBAUM, HARTLEY L. 65 ACT OR
210 W. HANSELL ST., THOMASVILLE 31792

FERNANDEZ, JOSE A. 65 ACT FP
2205 OLD MONTICELLO RD., THOMASVILLE 31792

FONTANA, NORVERTO A. 65 ACT FP
P. O. BOX 1867, THOMASVILLE 31792

HANCOCK, S. L. 65 OE1
2ND AVE., S. E., CAIRO 31728

HODGES, C. HUBERT, JR. 65 ACT U
808 GORDON AVE., THOMASVILLE 31792

JACKSON, ROBERT W. 65 AF ORS
P. O. BOX 978, THOMASVILLE 31792

KING, J. T. 65 ACT OALR
THOMASVILLE 31792

KING, JOHN T., JR. 65 ACT
P. O. BOX 1919, THOMASVILLE 31792

LANE, GEO M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

LEAR, THOMAS F., JR. 65 ACT SU
P. O. BOX 1912, THOMASVILLE 31792

LITTLE, FRANK A. 65 ACT ANES
109 TUXEDO DR., THOMASVILLE 31792

MALONE, RANDOLPH A. 65 ACT PD
413 GORDON AVENUE, THOMASVILLE 31792

MAXWELL, ROBERT B. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792

MCCOLLUM, WILLIAM 65 ACT
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

MCKENZIE, DONALD J. 65 ACT U
935 S. BROAD ST., THOMASVILLE 31792

MIDDLETON, MILTON G. 65 ACT
MENTAL HEALTH CENTER, THOMASVILLE 31792

MILLER, FRANK R. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792

MIMS, OSCAR M. 65 ACT I
THOMASVILLE 31792

MORTON, WM. J. 65 ACT
S. BROAD ST., CAIRO 31728

MULLER, GERALD B. 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792

MURPHY, FREO E., JR. 65 ACT OR
THOMASVILLE 31792

NEEL, JULIAN B. 65 ACT SL
207 E. JACKSON ST., THOMASVILLE 31792

PAYNE, JOHN F. 65 ACT OR
210 W. HANSELL ST., THOMASVILLE 31792

PEPIN, HENRY S. 65 ACT FP
602 E. SEIXAS ST., THOMASVILLE 31792

PETTIT, MANSON B. 65 ACT P
PINETREE BLVD., THOMASVILLE 31792

RAWLINGS, JOE O. 65 ACT FP
918 S. BROAD ST., THOMASVILLE 31792

REID, JAMES W. 65 ACT
THOMASVILLE 31792

REYNOLDS, G. THOMAS 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792

ROMINE, BENJAMIN W. 65 ACT FP
P.O. BOX 232, QUITMAN 31643

SHEALY, L. M. 65 ACT FP
P. O. BOX 631, QUITMAN 31643

SHEPARD, KIRK 65 OE1 SL
204 JURMIS ST., THOMASVILLE 31792

SINGLETON, C. K. 65 ACT
FIRST AVENUE, S. E., CAIRO 31728

STRESE, FRITZ W. 65 ACT FP
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

STORY, JAMES L. 65 ACT SU
505 GORDON AVE., THOMASVILLE 31792

STRESE, FRITZ W. 65 ACT FP
ARCHBOLD MEM. HOSP., THOMASVILLE 31792

TANNER, MAURICE B. 65 ACT R
P.O. BOX 1001, THOMASVILLE 31792

TAYLOR, JAMES P. 65 ACT OBG
507 GORDON AVE., THOMASVILLE 31792

TAYLOR, WARREN A. 65 ACT SL
PROF. BLDG. SIEXAS ST., THOMASVILLE 31792

TREVEJO, WILLIAM A. 65 ACT ANES
1616 E. WASHINGTON ST., THOMASVILLE 31792

TUCK, ALBERT C., O.D.S. 65 AF
P.O. BOX 978, THOMASVILLE 31792

WATT, CHARLES H., JR. 65 ACT SL
900 GORDON AVE., THOMASVILLE 31792

WATT, WILLIAM VANCE 65 ACT SL
900 GORDON AVENUE, THOMASVILLE 31792

WINE, MERVIN B. 65 ACT AL
THOMASVILLE 31792

ZAVALETA, A. A. 65 ACT TS
GORDON AVE., THOMASVILLE 31792

66—TIFT

BOWYER, FRANK P. 66 ACT PD
418 N. PARK AVE., TIFTON 31794

BRIDGES, W. L., JR. 66 ACT PD
714 E. 18TH, TIFTON 31794

DAVIS, F. MORRIS 66 ACT FP
820 TIFT AVE., TIFTON 31794

DAVIS, TERRELL L. 66 ACT PD
714 E. 18TH ST., TIFTON 31794

DIXON, SAMMIE 66 ACT OBG
1493 KENNEDY RD., TIFTON 31794

EDMONDSON, T. L. 66 ACT FP
TIFTON 31794

FLOWERS, EUGENE MONROE 66 ACT FP
TIFTON 31794

JARRETT, HENRY K., JR. 66 ACT U
113 EAST SECOND STREET, TIFTON 31794

JONES, R. E. 66 ACT FP
TIFTON 31794

KARSTEN, MIKELL B. 66 ACT SU
P.O. BOX 989, TIFTON 31794

KIRKPATRICK, J. F., JR. 66 ACT SL
714 E. 18TH ST., TIFTON 31794

LUCAS, PAUL WARREN 66 ACT OALR
TIFTON 31794

PITTMAN, CARL S. 66 OE5
TIFTON 31794

PITTMAN, CARL S., JR. 66 ACT FP
TIFTON 31794

PRIETO, EDWARD A. 66 ACT ANES
702 W. 6TH ST., TIFTON 31794

SAPP, GERALD L. 66 ACT OR
P.O. BOX 1368, TIFTON 31794

SMITH, DON T. 66 ACT FP
1824 N. LEE ST., TIFTON 31794

SMITH, ROBLEY O. 66 ACT FP
P. O. BOX 788, TIFTON 31794

TURNER, JOSEPH M. 66 ACT I
P. O. BOX 983, TIFTON 31794

WIGHT, ROBERT P. 66 ACT I
P. O. BOX 1186, TIFTON 31794

ZIMMERMAN, CHAS. 66 OE5 FP
TIFTON 31794

ZIMMERMAN, W. F. 66 OE1 FP
TIFTON 31794

68—TROUP (Heard)

ALMAND, JOSEPH M., JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240

BAILEY, A. GLENN 68 ACT SL
303 SMITH ST., LA GRANGE 30240

BASKIN, HENRY J. 68 ACT I
303 SMITH ST., LAGRANGE 30240

BYARS, STEVENS 68 ACT PH
406 COUNTRY CLUB RD., LAGRANGE 30240

CHAMBERS, J. W. 68 ACT I
307 N. LEWIS ST., LAGRANGE 30240

CHOI, SUN IK 68 ACT ANES
801 CHEROKEE RD., LAGRANGE 30240

COPELAND, ROBERT B. 68 ACT I
303 SMITH ST., LAGRANGE 30240

COUSINS, ALBERT L. 68 S I
303 SMITH ST., LAGRANGE 30240

COWART, CHARLES T. 68 ACT SL
718 LA ROSE TERR., LAGRANGE 30240

DOLAN, JOSEPH A. 68 ACT OBG
311 S. LEWIS ST., LAGRANGE 30240

DUTTERA, MAURICE J., JR. 68 ACT H
303 SMITH ST., LAGRANGE 30240

EASLEY, CURRAN S., JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240

FACKLER, WILLIAM B., JR. 68 ACT I
LAGRANGE 30240

FISHER, GEORGE B. 68 ACT
FRANKLIN 30217

GRACE, KENNETH O. 68 ACT SL
206 CHURCH ST., LAGRANGE 30240

HAMMETT, H. HILT, JR. 68 ACT OALR
HAMMETT BLDG., LAGRANGE 30240

HENDRICKS, WILLIS M. 68 ACT OBG
LAGRANGE 30240

HOLDER, J. S. 68 ACT SL
LAGRANGE 30240

HUTCHINSON, W. L. 68 ACT OBG
311 S. LEWIS STREET, LAGRANGE 30240

KRAFKA, JOSEPH F. 68 ACT PATH
CITY CO. HOSP., VERNON RD., LAGRANGE 30240

LEVERETT, EDWARD 68 ACT
432 GORDON CIRCLE, LA GRANGE 30240

LEWIS, EARLE 68 OE1 I
303 SMITH ST., LAGRANGE 30240

LINZ, WERNER A. 68 ACT U
303 SMITH ST., LAGRANGE 30240

MADRELL, ROBERT S. 68 ACT OBG
311 S. LEWIS ST., LA GRANGE 30240

MAJOR, CECIL P. 68 ACT
303 SMITH STREET, LAGRANGE 30240

MCCRARY, GEORGE ALFRED 68 ACT OR
303 SMITH ST., LA GRANGE 30240

MITCHELL, J. T. 68 ACT R
CITY-COUNTY HOSPITAL, LAGRANGE 30240

MOLYNEAUX, E. W. 68 ACT FP
HAMMETT BLDG., LAGRANGE 30240

MORGAN, J. C. 68 OE5 SL
WEST POINT 31833

MORGAN, JAMES C., JR. 68 ACT OALR
P. O. BOX 590, WEST POINT 31833

NAIK, MADHAV V. 68 ACT SL
ENOCH CALLAWAY CANCER CN, LAGRANGE 30240

NORMAN, LEWIS G., JR. 68 ACT SL
WEST POINT 31833

ONEAL, R. S. 68 OE5 FP
LAGRANGE 30240

RINKER, GEORGE E. 68 ACT PATH
CITY-COUNTY HOSP., LAGRANGE 30240

SMITH, ROBERT R. 68 ACT SL
828 PINEY WOODS DR., LAGRANGE 30240

TIDWELL, OWEN K. 68 ACT R
CITY-COUNTY HOSP., LA GRANGE 30240

TURNER, J. R. 68 ACT
LAGRANGE 30240

WAMMOCK, HOKE 68 ACT SL
ENOCH CALLAWAY CANCER CLINIC LAGRANGE 30240

WAMMOCK, VIRGENE S. 68 ACT O
771 LAKEWOOD DR., LA GRANGE 30240

WEST, JOHN T. 68 ACT SU
VERNON RD., LAGRANGE 30240

WHITEHEAD, C. MARK 68 ACT L
LAGRANGE 30240

WHITEHEAD, C. MARK, JR. 68 ACT L
303 SMITH ST., LAGRANGE 30240

69—UPSON (Pike)

ALLEN, LAWRENCE LANIER 69 ACT FP
211 THURSTON STREET, THOMASTON 30286

ANTHONY, H.F., JR. 69 ACT R
P. O. BOX 170, THOMASTON 30286

BLACKBURN, J. D. 69 OE5 OR
211 THURSTON AVE., THOMASTON 30286

BREWTON, SAMUEL A. JR. 69 ACT L
612 W. GORDON RD., THOMASTON 30286

CARTER, ROBERT L. 69 OE5 FP
THOMASTON 30286

DALLAS, R. E. 69 ACT FP
211 E. THOMASTON ST., THOMASTON 30286

DALLAS, WM. M., JR. 69 ACT SL
405 W. MAIN ST., THOMASTON 30286

DEEN, JOHNNY T. 69 ACT OPH
THOMASTON 30286

GARDNER, NORMAN P. 69 ACT FP
101 AVENUE F, THOMASTON 30286

GOWER, W. J. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286

HEAD, D. L., JR. 69 ACT FP
E. THOMPSON ST., THOMASTON 30286

HOLLOWAY, ALFRED M. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286

KELLUM, J. M. 69 ACT SU
THOMASTON 30286

OXFORD, WILLIAM M. 69 ACT SU
405 W. MAIN ST., THOMASTON 30297

PATRICK, JOHN W. 69 ACT R
P.O. BOX 170, THOMASTON 30286

POTITONG, BANLU 69 ACT I
211 THURSTON AVE., THOMASTON 30286

POTITONG, PRATOOM 69 ACT PD
211 THURSTON AVE., THOMASTON 30286

SAPPINGTON, T. A. 69 ACT FP
612 W. GORDON ST., THOMASTON 30286

SHACKLETT, ROBERT S. 69 ACT PATH
801 W. GORDON ST., THOMASTON 30286

TYLER, HERBERT D. 69 ACT I
612 W. GORDON ST., THOMASTON 30286

WODDALL, JAMES A. 69 ACT
316 W. GORDON ST., THOMASTON 30286

WOODALL, WM. PRUITT 69 ACT
316 W. GORDON ST., THOMASTON 30286

70—WALKER-CATOOSA-DADE

ADAMS, JOHN W., JR. 7C ACT PATH
HUTCHESON MEM. HOSP., FT. OGLETHORPE 30741

ADKINS, THOMAS E. 7C ACT FP
789 CHICKAMAUGA AVE., ROSSVILLE 30741

ALISAGO, ANDRES J. JR. 7C ACT ANES
J.L. HUTCHESON MEM. HOSP.,FT. OGLE 37404

CASH, TED D. 7C ACT FP
P. O. BOX 846, LAYFAYETTE 30728

CASTILLO, ANTONIO R. 7C ACT FP
306 CHICKAMAUGA AVE., ROSSVILLE 30741

COCHRAN, T. A. 7C ACT FP
RINGGOLD 30736

CRAWLEY, WILLIAM D. 7C ACT OBG
787 CHICKAMAUGA AVE., ROSSVILLE 30741

CURETON, M. K. 7C DE5 PH
6 SUNSET DR., LAFAYETTE 30727

CURETON, RICHARD K. 7C ACT R
HUTCHESON HOSP., FT. OGLETHORPE 30742

CURTIS, THOMAS H. 7C ACT GBG
219 FIRST ST., FT. OGLETHORPE 30742

DERRICK, HOWARD C., JR. 7C ACT FP
LAFAYETTE 30728

DUHON, FRED J. 7C ACT FP
DOCTORS CLINIC, LAFAYETTE 30728

ELROD, BRUCE A. 7C ACT PATH
823 MCCALLIE AVE., CHATTANOOGA, TN. 37403

GOOLSBY, SARA L. 7C ACT
211 ANDREWS ST., ROSSVILLE 30741

GREENE, RALPH P. 7C ACT FP
P. O. BOX 460, RINGGOLD 30736

HANSEN, RICHARD A. 7C ACT FP
WILDWOOD HOSP., WILDWOOD 30757

HAYES, THOMAS E. 7C ACT SU
711 MEDICAL ARTS, CHATTANOOGA, TN. 37404

HIXSON, GORDON L. 7C ACT R
TRI COUNTY HOSPITAL, FT. OGLETHORPE 30742

HUTCHISON, NORTON H. 7C ACT FP
TRENTON 30752

JOHNSON, E. G. 7C ACT SU
546 MCALLIE AVE., CHATTANOOGA, TENN. 37402

JONES, ROBERT T. 7C ACT
LAFAYETTE 30728

JUSTICE, OREN W. 7C ACT FP
LAFAYETTE MED. CTR., LAFAYETTE 30728

KINARD, GARLAND E. 7C ACT FP
118 HOWARD ST., ROSSVILLE 30741

KITCHENS, S. B. 7C DE5 FP
LAFAYETTE 30728

KOCACITAK, SAFIN S. 7C ACT SU
TRI-COUNTY HOSP., FT. OGLETHORPE 30742

LASKY, RICHARD S. 7C ACT U
409 DODD AVENUE, CHATTANOOGA TN 37404

LEGNER, STANLEY 7C ACT FP
7816 STONEHENGE DR., CHATTANOOGA, TN 37421

MARTYNSKI, STANISLAW 7C ACT PD
HUTCHESON MEM. HOSP., FT. OGLETHORPE 30742

POPE, ROY JR. 7C ACT FP
CHICKAMAUGA 30707

RANDLE, GERALD P. 7C ACT FP
#6, BLDG. 7, BENBOW F, OXFORD, MS 38655

SANCHEZ, FRANCISCO R. 7C ACT FP
LAFAYETTE MEDICAL CENTER, LAFAYETTE 30728

SIMONTON, FRED H. 7C DE5 FP
CHICKAMAUGA 30707

SMILEY, F. JONES 7C ACT GBG
219 FIRST ST., FT. OGLETHORPE 30742

STEPHENSON, CHAS. W. 7C DE5 FP
RINGGOLD 30736

SWIFT, CHARLES RAY 7C ACT PATH
3827 RINGGOLD RD., CHATTANOOGA, TN. 37412

TERRELL, WARREN 7C ACT FP
NO CURRENT ADDRESS

VASSEY, G. C. 7C ACT FP
791 CHICAMAUGA AVE., ROSSVILLE 30707

71—WALTON

AKERY, EARL J. 71 ACT FP
WALTON CLINIC, MONROE 30655

BARTON, JAMES HOWARD 71 ACT
SOCIAL CIRCLE 30279

BRISCO, C. D. 71 DE5 I
MONROE 30655

ENSLEN, PHILLIP J. 71 ACT FP
247 ALCOVA ST., MONROE 30655

HUIE, LYNN M. 71 ACT FP
MONROE 30655

MORELAND, C. C. 71 ACT
WALTON CLINIC, MONROE 30655

TANKESLEY, ROBERT M. 71 ACT R
437 PLANTATION DR., MONROE 30655

72—WARE
(Bacon, Brantley, Pierce)

ADKINS, H. T. 72 A PH
P. O. DRAWER 1110, WAYCROSS 31501

BATES, ROGER A. 72 ACT SU
204 PLANTATION DR., WAYCROSS 31501

BATES, W. B., JR. 72 ACT FP
WAYCROSS 31501

BICKERSTAFF, JAMES W., JR 72 OCT OR
1921 ALICE ST., WAYCROSS 31501

BROWN, EDWARD B. 72 ACT GBG
P. O. BOX 177, WAYCROSS 31501

CALHOUN, W. C. 72 ACT OB
P. O. BOX 1091, WAYCROSS 31501

CAMPBELL, JOHN C. 72 ACT U
408 ZACHRY ST., WAYCROSS 31501

CARBAUGH, ROBERT G. 72 ACT ANES
1921 ALICE ST., WAYCROSS 31501

CLARK, SPURGEON WM., JR. 72 ACT OPH
P. O. BOX 951, WAYCROSS 31501

DANEMAN, E. A. 72 ACT
P. O. DRAWER 152, GAMBIER, OHIO 43022

DAVIS, ALFRED L., JR. 72 ACT PD
P. O. BOX 71, BLACKSHEAR 31516

DAVIS, FLOYD E. 72 ACT FP
1921 ALICE ST., WAYCROSS 31501

DURRENCE, LEONARD C., JR. 72 ACT FP
BLACKSHEAR CLINIC, BLACKSHEAR 31516

FARRIS, JOHN DUNCAN 72 ACT OBG
P. O. BOX 177, WAYCROSS 31501

FERRELL, T. J., JR. 72 ACT I
1921 ALICE ST., WAYCROSS 31501

FLESCH, W. L. 72 ACT U
BOX 1190, WAYCROSS 31501

GOLDWASSER, FRED E. 72 ACT FP
ALMA 31510

HEATH, GEORGE S. 72 ACT FP
P. O. BOX 1131, WAYCROSS 31501

HEATH, HEZEKIAH K., JR. 72 ACT
P. O. BOX 1131, WAYCROSS 31501

HENDRY, KATHERINE MCM. 72 ACT FP
BLACKSHEAR 31516

HENDRY, WM. A. 72 DE1 FP
BLACKSHEAR 31516

JACOBS, IVEY 72 ACT ALR
P. O. BOX 882, WAYCROSS 31501

JACOBS, L. DAVIS 72 ACT FP
403 LISTER ST., WAYCROSS 31501

LEE, WALTER E., JR. 72 ACT FP
BOX 737, WAYCROSS 31501

LEWIS, WILEY B. 72 ACT FP
1507 ALICE ST., WAYCROSS 31501

LOPEZ, ERNESTO G. 72 ACT PATH
WAYCROSS MEM. HOSP., WAYCROSS 31501

MARTINEZ, JOS. 72 ACT ANES
MEM. HOSP., WAYCROSS 31501

MCCLARIN, WILLIAM M., JR. 72 ACT D
202 FOLKS ST., WAYCROSS 31501

MCGOUGAN, M. T. 72 ACT SU
1921 ALICE ST., WAYCROSS 31501

OCONNELL, MICHAEL J. 72 ACT OR
1507 ALICE ST., WAYCROSS 31501

PACKER, ROBERT M., JR. 72 ACT I
P.O. BOX 899, WAYCROSS 31501

POMEROY, W. L. 72 DE5 SU
WAYCROSS 31501

POMEROY, WILLIAM L., JR. 72 ACT I
1921 ALICE ST., WAYCROSS 31501

SHUMAN, VILDA 72 ACT PD
WAYCROSS 31501

SMITH, LEO 72 ACT CALR
BOX 778, WAYCROSS 31501

SMITH, ROBERT C. 72 ACT R
P. O. BOX 938, WAYCROSS 31501

STEBLER, MICHAEL E. 72 ACT PATH
MEMORIAL HOSPITAL, WAYCROSS 31501

TAYLOR, JAMES W. 72 ACT OPH
P.O. BOX 778, WAYCROSS 31501

THOMPSON, CLEVELAND, III 72 ACT SU
410 ZACHRY ST., WAYCROSS 31501

TRIANA, CARLOS R. 72 ACT SU
PATTERSON 31557

VICTOR, SAMUEL 72 ACT FP
1921 ALICE ST., WAYCROSS 31501

WAXLER, EDWARD B. 72 ACT I
P.O. BOX 899, WAYCROSS 31501

WILSON, OHLEN RUDOLPH 72 ACT
ALMA 31510

WYNN, O. C. 72 DE5 FP
861 FOLKS ST., WAYCROSS 31501

YEOMANS, NEAL F. 72 ACT R
WAYCROSS 31501

74—WASHINGTON

GILMORE, THOMAS W., JR. 74 ACT I
P. O. BOX 190, SANDERSVILLE 31082

HELTON, B. L. 74 DE5 FP
524 WASHINGTON AVE., SANDERSVILLE 31082

HELTON, WILLIAM S. 74 ACT FP
522 WASHINGTON AVE., SANDERSVILLE 31082

HOLMES, DEAN LEE 74 ACT
524 SPARTA RD., SANDERSVILLE 31082

HURT, MARION W. 74 ACT FP
109 W. CHURCH ST., SANDERSVILLE 31082

NEWSOM, N. J. 74 DE5 I
P. O. BOX 704, SANDERSVILLE 31082

RAWLINGS, WILLIAM 74 ACT FP
524 SPARTA RD., SANDERSVILLE 31082

TAYLOR, WILLIAM E. 74 ACT FP
SMITH ST., TENNILLE 31089

75—WAYNE

HARRELL, E. L. 75 ACT
RT. 4, BOX 424, JESUP 31545

HITT, WILLIAM A. 75 ACT FP
P. O. BOX 604, JESUP 31545

MCGAHEE, OLLIE O., JR. 75 ACT FP
P. O. BOX 937, JESUP 31545

MILLER, ROBERT E. 75 ACT
P. O. BOX 10, JESUP 31545

MOODY, RICHARD A. 75 ACT
P. O. BOX 456, JESUP 31545

PUMPELLY, ROBERT A. 75 ACT FP
P. O. BOX 1097, JESUP 31545

YEOMANS, JAMES W. 75 ACT SU
P. O. BOX 67, JESUP 31545

76—WHITFIELD-MURRAY

BARNWELL, WILLIAM L. 76 ACT OPH
1217 MEMORIAL DRIVE, DALTON 30720

BLACKMAN, WILLIAM M. 76 ACT OPH
1217 MEMORIAL DR., DALTON 30720

BOGGESS, NEIL D., JR. 76 ACT
1012 BURLEYSON DR., DALTON 30720

BOOZER, ALBERT MARION 76 ACT FP
DALTON MEM. ARTS BLDG., DALTON 30720

BOWERS, ROBERT E. 76 OE2 FP
721 GLENWOOD DR., CHATTANOOGA, TENN. 37404

BRADLEY, PAUL L. 76 ACT SU
P.O. 1969, DALTON 30720

BRADLEY, R. H. 76 DE5
CHATSWORTH 30705

CAREY, FLOYD THOMAS 76 DE2 FP
UNIV. OF MISS., JACKSON, MISS. 39200

CARSON, W. P. 76 ACT SU
P. O. BOX 129, DALTON 30720

CHEATHAM, JAMES S. 76 ACT P
201 S. HAMILTON ST., STE 408, DALTON 30720

COUNCIL, BENJAMIN P. 76 ACT OTO
1305 BROADRICK DR., DALTON 30720

EASLEY, CONRAD H. 76 ACT SU
1401 BURLEYSON DR., DALTON 30720

EIDSON, ROBERT H. 76 ACT OBG
1217 MEMORIAL DR., DALTON 30720

FARROW, POYAL T. 76 ACT PD
ALABAMA ST., DALTON 30720

FELKER, FORT F., JR. 76 ACT
216 N. PENTZ ST., DALTON 30720

FORSHNER, JOHN G. 76 ACT D
1217 MEMORIAL DR., DALTON 30720

FULGHUM, THOMAS F. 76 ACT I
HEALTH DEPT., DALTON 30720

GENT, JACK 76 ACT SU
P. O. BOX 1065, DALTON 30720

GIDDENS, RICHARD O. 76 ACT SU
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GREGORY, JAMES R. 76 ACT OBG
1217 MEMORIAL DR., DALTON 30720

HENSON, PAUL E., JR. 76 ACT U
BROADRICK DR., DALTON 30720

JOHNSTON, HARRY B., JR. 76 ACT SU
500 N. THIRD AVE., CHATSWORTH 30705

JONES, J. SHERWOOD 76 ACT I
MEMORIAL DR., DALTON 30720

LEVY, LOUIS I. 76 ACT PD
1968 NORTH AVE., COLUMBUS 31901

LUMPKIN, MURRAY B. 76 ACT SU
P. O. BOX 987, DALTON 30720

MAHAN, D. R., JR. 76 ACT FP
MEMORIAL DR., DALTON 30720

MARLOW, JAMES E. 76 ACT FP
CLEVELAND HIGHWAY, DALTON 30720

MARTIN, H. U. 76 ACT R
P. O. BOX 1166, DALTON 30720

MCDANIEL, WILLIAM L., JR. 76 ACT FP
1205 MEMORIAL DR., DALTON 30720

MCGHEE, EARL T. 76 ACT FP
BURLEYSON DR., DALTON 30720

MCKINNEY, JAMES E. 76 ACT U
MEDICAL ARTS BLDG., DALTON 30720

MYERS, JAMES S. 76 ACT R
P. O. BOX 1285, DALTON 30720

NOWELL, DAVID M. 76 ACT OBG
P. O. BOX 1138, DALTON 30720

OOSTERHOUDT, JAMES J. 76 ACT SU
P. O. BOX 924, DALTON 30720

RAITZ, ROBERT L. 76 ACT
BURLEYSON DR., DALTON 30720

RAMOS, FERNANDO Q. 76 ACT SU
120 WALNUT ST., CHATSWORTH 30705

REDFEARN, JAMES A., JR. 76 ACT
MEMORIAL DRIVE, DALTON 30720

RIZO, MIGUEL A. 76 ACT P
1217 MEMORIAL DR., DALTON 30720

ROSE, CORDT E. 76 ACT ANES
110 CHINQUAPIN WAY, ATHENS 30601

ROSEN, BARRETT F. 76 DE2 OR
P. O. BOX 548, DALTON 30720

RUSSELL, FREDERICK L. 76 A FP
P. O. BOX 564, DALTON 30720

SANDERS, DRAYTON M., II 76 ACT I
MEMORIAL DR., DALTON 30720

SANDERS, J. LARRY 76 ACT OBG
1217 MEMORIAL DR., DALTON 30720

SAPP, PHILIP B. 76 ACT ER
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114 MEMORIAL DR., DALTON 30720

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WALKER, OTTIS 76 ACT FP
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1219 MEMORIAL DR., DALTON 30720

WHITFIELD, T. W. 76 ACT FP
1221 MEMORIAL DR., DALTON 30720

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200 1/2 KING STREET, DALTON 30720

YEAPGIN, LOYD C. 76 ACT FP
P. O. BOX 429, DALTON 30720

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WASHINGTON 30673

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P. O. BOX 370, WASHINGTON 30673

POLLOCK, CHARLES E. 78 ACT SU
WASHINGTON 30673

POLLOCK, JOHN EDWARD JR. 78 ACT FP
GORDON ST., WASHINGTON 30673

WILLS, C. E., JR. 78 ACT FP
WASHINGTON 30673

WYSONG, EDWARD D. 78 ACT FP
123 GORDON ST., WASHINGTON 30673

79—WORTH

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MCLEAN, FREDERICK L. 79 ACT FP
407 MCPHAUL ST., SYLVESTER 31791

MORGAN, ROBERT T. 79 ACT FP
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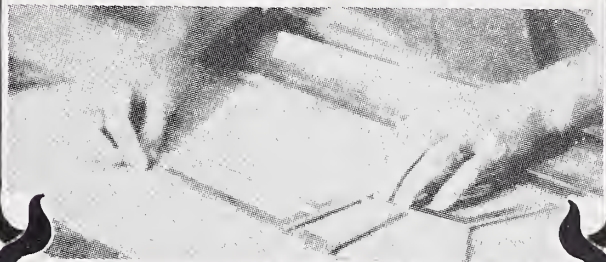
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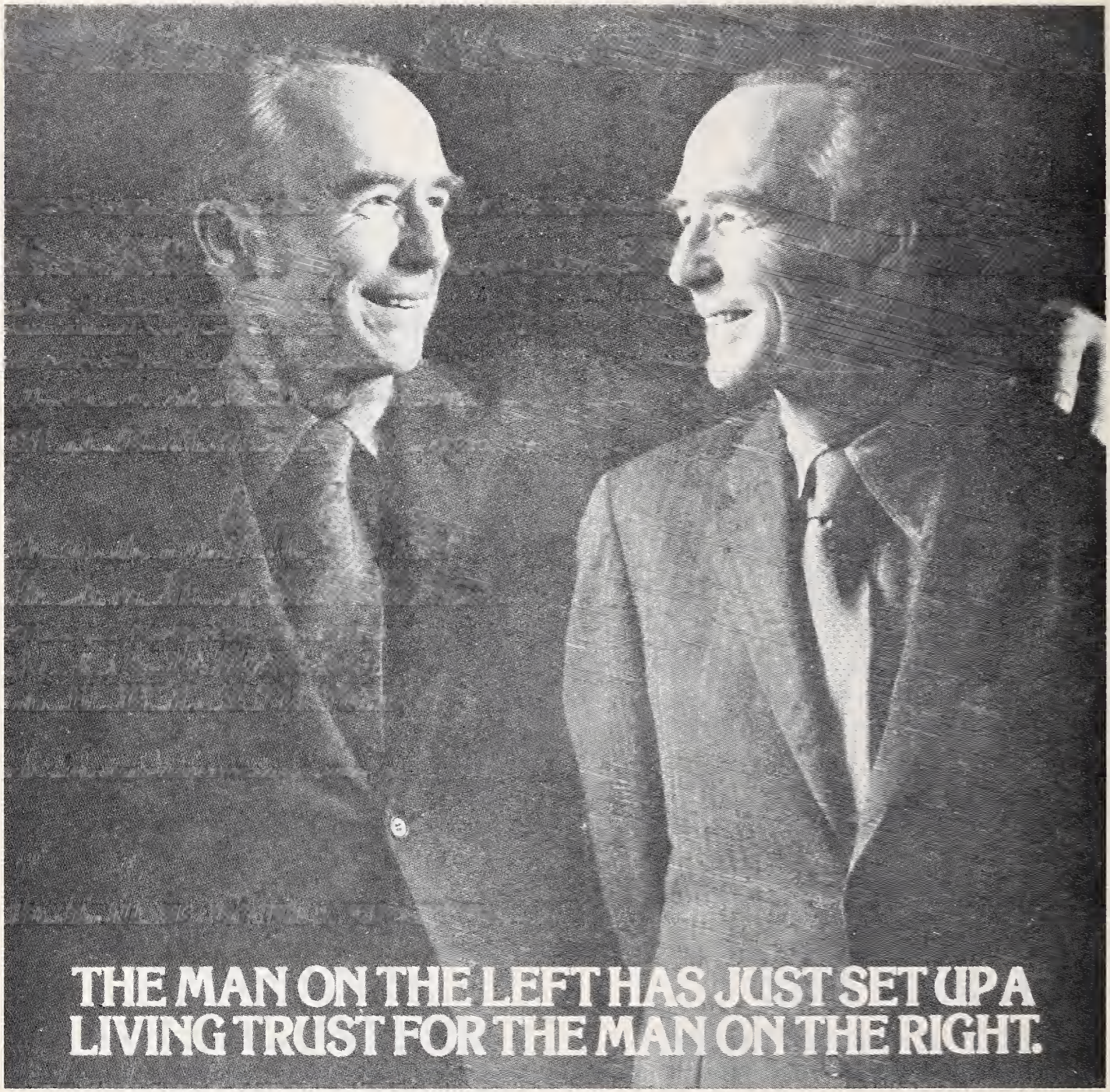
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Principles of Medical Ethics
American Medical Association
1957

PREAMBLE.—These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

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